S. HRG. 105–735

BETRAYAL: THE QUALITY OF CARE IN CALIFORNIA NURSING HOMES

HEARINGS

BEFORE THE

SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

ONE HUNDRED FIFTH CONGRESS

SECOND SESSION

WASHINGTON, DC

JULY 27 AND 28, 1998

Serial No. 105–30



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BETRAYAL: THE QUALITY OF CARE IN CALIFORNIA NURSING HOMES

MONDAY, JULY 27, 1998

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Washington, DC.

The committee met, pursuant to notice, at 1:07 p.m., in room SH–216, Hart Senate Office Building, Hon. Charles Grassley, (chairman of the committee) presiding.

Present: Senators Grassley, Burns, Breaux, and Kohl.

OPENING STATEMENT OF SENATOR CHARLES GRASSLEY, CHAIRMAN

The CHAIRMAN. I am Senator Chuck Grassley, chairman of the Aging Committee. To my right is ranking minority member, Senator Breaux. Other members are here as well, and I thank each of you for coming. I welcome you to the 2-day hearing that will focus on the quality of care in California nursing homes.

To our witnesses who came a long way, I say thank you. You have traveled for hours to be here to share your information with us. They are going to share with us their personal and, too often, painful experiences.

I also want to thank our panel of nursing home insiders. They have stepped forward to share with us the realities of working in a nursing home setting.

Of course, I would like to extend a special welcome to all of you here from the public. I think this large turnout shows the legitimate concern that people have about conditions of nursing homes.

Twelve years ago, there was this report out in a newspaper article, "No Place to Die: California Nursing Homes," the San Jose Mercury News. It tells all about, just page after page, as you can see, of the conditions in nursing homes 12 years ago. The headlines say that laws alone will not achieve reforms, et cetera, et cetera.

This report highlights neglect in California nursing homes. It is a horrifying testament to the lack of compassion and care that was provided to some of the most vulnerable, defenseless individuals—nursing home residents. As I said, that was 12 years ago.

About the same time that this report was printed, we had a National Institute of Medicine study being completed. The IOM study found noncompliance with Federal regulations to be widespread among nursing homes. It recommended strengthening Federal regulations for nursing homes and called for the imposition of stronger sanctions.

One year later, in 1987, the General Accounting Office—the GAO—reported that more than one-third of the nation's nursing homes were operating, and I want to quote from that report, "at a substandard level, below minimum Federal standards during three consecutive inspections."

At the same time, the Nursing Home Reform Act was passed and made into law by Congress and the President. This Act made the first major improvement to Federal regulations of nursing homes. It addressed quality of life and quality of care in nursing homes.

So I refer to the report from the San Jose Newspaper, the Institute of Medicine, the General Accounting Office, and what Congress did at that particular time to put this all within an historical context of why we are here today.

A dozen years ago, Congress fought the good fight. Congress identified unacceptable care being given to nursing home residents. Congress systematically and objectively studied these quality of care problems. Congress identified viable solutions. Congress legislated, regulations were issued, policies and procedures were implemented. All together an infrastructure was created to ensure that business as usual, when it came to nursing home residents and the industry, would be a thing of the past.

We thought that we had the problem licked, or maybe we just did not want to see beyond the laws, regulations, policies, and procedures. Sometimes not knowing and not looking is just plain easier. We never dreamed that we could see a headline like we saw then or that we would see it again. But, no such luck.

Now I would like to move to the background for today's hearing. About one year ago some serious allegations were brought to the committee's attention regarding the quality of care in California nursing homes. The allegations were shocking, the photographs sickening, and the graphic examples of neglect were almost unbelievable.

The shocking truth is that the committee was told that thousands of California nursing home residents were suffering and meeting with untimely deaths due to malnutrition, dehydration, pressure sores, and infections that spread from the urinary tract into the bloodstreams. Of course, these allegations were supported by hundreds, and maybe thousands, of death certificates.

So one year ago, seeing all of this, I could not stand by idly, as Chair of the Special Committee on Aging, in light of these grave allegations. On October 1, 1997, after a series of discussions with high-level officials at the General Accounting Office, I requested that a review be conducted into these allegations.

On a separate, but parallel track, I directed my staff to look into the issue of malnutrition in nursing homes. October 22 last year, I assembled a distinguished panel of experts to discuss this issue of malnutrition. These experts confirmed that malnutrition is frequent and often preventable, a condition that can be prevented, and is prevalent among too many nursing home residents.

At that time, we also explored what the industry and dieticians would call best practices used by a number of nursing homes to ensure that their residents receive the proper amount of nutrition daily.

I have personally visited nursing homes in Iowa to study these best practices. I have learned that, if it has the will, a nursing home can ensure that nursing home residents are fed and given enough water. These are the very basic ingredients of survival.

Also last October, an article appeared in TIME Magazine entitled, "Fatal Neglect." It highlighted neglect in California nursing homes.

So this all adds up to why we are here today to look at the California nursing homes and tomorrow to receive the report from the General Accounting Office.

I would like to make a brief comment on the politics of these hearings. If there is one issue in America that should rise above politics, it is this one. On this committee and on this issue, there will be no politics, there will be no partisanship. This issue is much too serious and much too important to become a political football.

I sent a letter to the President on July 15, this year, expressing the urgency of the situation in California, alerting him to these hearings that I am having. The President responded last week to my prodding, and I embrace the President's response. His initiatives were a constructive step forward. It is our job to maintain a cooperative spirit on fixing the problems in the nursing homes. It is also our Constitutional responsibility, as Congress, to hold the Administration's feet to the fire to ensure that these initiatives are implemented.

We have to remember that the initiatives themselves are only 50 percent of the solution. The other 50 percent is getting them implemented, and that is where our focus should turn now.

I raise the issue of politics for only one reason; last week in the President's remarks I detected a degree of partisanship. Perhaps it was in anticipation that these hearings would be used in a political way against the President. But let me assure the President, and the public, it is quite to the contrary. We cannot afford to serve this up as a political issue or in any political way, because it is too far serious of an issue. There is not one Republican who cares more about this matter than any Democrat, and vice versa. This issue will not be a political football in this committee, period.

The next 2 days are going to be difficult ones. The personal, often painful experiences and sometimes graphic testimony of our witnesses and nursing home insiders are compelling and disturbing. To imagine that these things are going on today in one or more nursing homes in the State of California is simply intolerable, and we will not stand for it.

Day two of this hearing will present us with the findings and recommendations of the GAO study that I had requested earlier. The GAO findings are troubling and sadly reminiscent of the past. The findings of this report are reinforced by HCFA's self-indictment which was released by the Administration last week by the President. This is one of the four volumes; a total of 900 pages. This report should have been out in July 1997. I am happy that it is out in time for these hearings.

Tomorrow, we are also going to hear from HCFA. HCFA is charged by law with ensuring that the enforcement of Federal care requirements for nursing homes is adequate to protect the health, safety, welfare, and rights of nursing home residents.

We will also provide an opportunity to representatives of the nursing home industry to address the state of affairs in California's nursing homes, and we are going to let them speak tomorrow as well. The State of California was invited to testify, but declined the invitation.

In conclusion, there are a few things that I want to emphasize before I turn to Senator Breaux.

First, this hearing is about California nursing homes. It is not about all nursing homes.

Second, I will continue exploring the issue of the quality of care in nursing homes as a general matter over the upcoming year. I feel compelled to do so. Elderly nursing home residents, those who do not have a voice, deserve no less. We have a duty and responsibility to know the truth regarding the quality of care being provided to nursing home residents. I am hopeful that the news is good. I will be prepared if it is bad.

In the end, whatever we learn over the next 2 days will not be in vain. The quality of care in California's nursing homes will improve because we, as Americans, as fathers, mothers, daughters, and sons can accept nothing less than success.

[The prepared statement of Senator Grassley follows:]

PREPARED STATEMENT OF SENATOR CHARLES GRASSLEY

Good afternoon. Welcome to this two-day hearing that will focus on the quality of care in California nursing homes. I would like to begin by thanking our witnesses. Many came from across the United States to be here today. They will share with us their personal, and all too often painful, experiences. I also want to thank our panel of nursing home insiders. They have stepped forward to share with us the realities of working in the nursing home setting. And of course, I would like to extend a special welcome to members of the public.

Twelve years ago, a special report was issued by the San Jose Mercury News. I have a copy of that report right here. As you can see, the title is "NO PLACE TO DIE." This report highlights neglect in California nursing homes. It is a horrifying testament to the lack of compassion and care that was provided to some of the most vulnerable and defenseless individuals—nursing home residents.

Around the same time that this report was printed, an Institute of Medicine study was completed. That study became known as the IOM study. It found noncompliance with federal regulations to be widespread among nursing homes. It recommended strengthening federal regulations for nursing homes and called for the imposition of stronger sanctions.

One year later, in 1987, the General Accounting Office (GAO) reported that more than one-third of the nation's nursing homes were operating, and I quote, "at a substandard level, below minimum federal standards during three consecutive inspections." That same year, the Nursing Home Reform Act was passed and made law. This Act made the first major improvements to the federal regulation of nursing homes. It addressed quality of life and quality of care issues in nursing homes.

It is within that historical context that we are here today. A dozen years ago, Congress fought the GOOD FIGHT. Congress identified unacceptable care being given to nursing home residents. Congress systematically and objectively studied these quality of care problems. Congress identified viable solutions. Congress legislated. Regulations were issued. Policies and procedures were implemented. An infrastructure was created to ensure that "business as usual," when it came to the nursing home industry, was a thing of the past.

We thought we had the problem licked. Or, maybe we just didn't want to see beyond the laws, regulations, policies and procedures. Sometimes not knowing and not looking is just plain easier. We never dreamed that we could again see a headline that in any way resembled this one. But no such luck.

I want to begin by talking about how we got to this hearing. About one year ago, some serious allegations were brought to the Committee's attention regarding the quality of care in California nursing homes. The allegations were shocking. The photographs sickening. And the graphic examples of neglect were almost unbelievable. The shocking truth is that the Committee was told that thousands of California

nursing home residents were suffering and meeting with untimely deaths due to malnutrition, dehydration, pressure sores, and infections that spread from the urinary tract to the bloodstream. These allegations were supported by hundreds, maybe even thousands, of death certificates.

I could not stand idly by as Chair of the Special Committee on Aging in light of these grave allegations. On October 1, 1997, after a series of discussions with high level officials at the General Accounting Office (GAO), I requested that a review be conducted into these allegations. On a separate but parallel track, I directed my staff to look into the issue of malnutrition in nursing homes. On October 22, 1997, we assembled a distinguished panel of experts to discuss this issue. These experts confirmed that malnutrition is a frequent and often preventable condition among nursing home residents.

At that time, we also explored the "best practices" used by a number of nursing homes to ensure that their residents receive the proper amount of nutrition daily. I have personally visited nursing homes in Iowa to study these "best practices." I have learned that if you have the WILL, a nursing home CAN ensure that nursing home residents are fed and given enough water—the very basics of survival. Also last October, an article appeared in TIME Magazine entitled "Fatal Neglect." It highlighted neglect in California nursing homes. So that is how we came to be here today at this hearing.

I'd like to make a brief comment on the politics of these hearings. If there is one issue in America that should rise above politics, it is this one. On this Committee on this issue, there will be NO politics. No partisanship. This issue is much too serious, much too important to become a political football.

I sent President Clinton a letter on July 15, 1998 expressing the urgency of the situation in California. The President finally responded last week to my prodding. I embrace the President's response. His initiatives were a constructive step forward. It's our job to maintain a cooperative spirit on fixing the nursing home problems. But it's also our job to hold the Administration's feet to the fire to ensure these initiatives get implemented.

We have to remember that the initiatives themselves are only 50 percent of the solution. The other 50 percent is getting them implemented. That's where our focus should turn now.

I raise the issue of politics only for one reason. Last week in the President's remarks, I detected a degree of partisanship. Perhaps it was in anticipation that these hearings would be used in a political way against the President.

Let me assure the President and the public that that is not the case. We can't afford to serve this issue up in any political way. It's far too serious. There isn't one Republican that cares more about this matter than any Democrat and vice versa. This issue will not be a political football with this Committee. Period.

The next two days are going to be difficult ones. The personal, often painful experiences and sometimes graphic testimony of our witnesses and nursing home insiders are compelling and disturbing. To imagine that these things are going on today in one or more nursing homes in the State of California is simply intolerable. We will not stand for it.

Day Two of this hearing will present us with the findings and recommendations of the GAO study I had requested earlier. The GAO findings are troubling and sadly reminiscent of the past. The findings of this report are reinforced by HCFA's self-indictment that was released by the Administration last week.

Tomorrow we will also hear from the Health Care Financing Administration (HCFA). HCFA is charged by law with ensuring that the enforcement of federal care requirements for nursing homes is adequate to protect the health, safety, welfare and rights of nursing homes residents. We will also provide an opportunity to representatives of the nursing home industry to address the state of affairs in California nursing homes tomorrow. The State of California was invited to testify as well but declined the Committee's invitation.

In conclusion, there are a few things that I want to emphasize before I turn to Senator Breaux. First, this hearing is about California nursing homes. It is not about all nursing homes. Second, I will continue exploring the issue of quality of care in nursing homes as a general matter over the upcoming year. I feel compelled to do so. Elderly nursing home residents—those who don't have a voice—deserve no less. We have a duty and responsibility to know the truth regarding the quality of care being provided to nursing home residents. I am hopeful that the news is good. I will be prepared if it is bad.

In the end, whatever we learn over the next two days will not be in vain. The quality of care in nursing homes WILL improve because we as Americans, fathers, mothers, daughters and sons can accept nothing less than success.

Senator Breaux.

STATEMENT OF SENATOR JOHN BREAUX

Senator BREAUX. Thank you very much, Mr. Chairman, and thanks to all of our witnesses who are going to be with us this morning, the audience for their attendance, and you for calling these hearings, which I think are very, very important.

With our obligation, as I have said this morning, to guarantee financial security in programs like Medicare and Medicaid also comes an equally, if not greater, importance in guaranteeing personal security. By financial security I simply mean that if a mom or dad or grandma or grandfather or any friend or relative is in a nursing home, that the American public has the right to know that the bills will be paid to the nursing homes, and the doctors and nurses will be paid. But they also have a right to know that the personal security of the patient in the nursing home is also going to be of a quality that all of us can be proud of in this country.

There are about 16,800 nursing homes in America. The majority of them do an outstanding job. 1.6 million people find themselves in nursing homes at any given time in this country, and the majority get quality, competent care. But if one-eighth or one-ninth or one-third of them are being mistreated and not properly cared for, not properly fed, not properly administered to, then that is too many.

I think that the gist of our hearings today and tomorrow will be to find out the nature and the scope of the problem. Is it pervasive? Is it just one state? I doubt it. How bad is it? Then to find out what we can do to remedy that problem. Do we need more laws? Maybe. But I suggest we probably just need to enforce the laws we currently have better than we have been enforcing them.

The National Auditors Association produced a fine document—the National State Auditors Association—and my State of Louisiana actually was the one that coordinated the audit on behalf of the National Auditors Association.

I was looking through some of their findings, and found interesting information; the study conducted in-depth investigations into nine states. In my own State of Louisiana, for example, the auditors found that only about 11 percent of the inspections of nursing homes that were not in substantial compliance resulted in civil monetary penalties or fines.

Louisiana recommended that the state agency fine all facilities that are found not to be in substantial compliance, with the idea of encouraging facilities to be in substantial compliance year round.

I think we would also find out that year-round compliance is important not just compliance on the day of the inspection. Any facility which has been inspected on the same day every year can probably pass that inspection that day, but how many of the other 364 days are they also going to be in compliance? I think we also need to look at how the inspections are conducted.

Finally, Mr. Chairman, this is something that everyone needs to be involved in. The states as agents for the Federal Government license nursing homes. They have the right to take away that license when nursing homes are not in compliance, in order to guarantee

that homes stay in compliance. Federal Government funds, in most cases, supply most of the financial money being used for long-term care. In my State, it is about an 80/20 match in the Medicaid program, and there are some Medicare services that go into nursing homes. So the Federal Government has a direct obligation to see to it that tax dollars are spent wisely.

I commend the Administration for their very, I think, aggressive proposal on how they want to address the problem.

Finally, I think all of us, as citizens, have to be more involved. Doctors go to nursing homes every day, and treat patients in nursing homes every day. We need them to be involved, by filing complaints when they see instances of noncompliance or abuse. Nurse practitioners and others who visit must be involved in this same manner. We need aggressive Attorneys General at a state level to be involved in making sure that, when necessary, prosecutions occur.

I think we have a lot of things we need to learn, and I think that we are going to find that everybody needs to be involved in solving the problem, and thank you for having the hearing.

[The prepared statement of Senator Breaux follows:]

PREPARED STATEMENT OF SENATOR JOHN BREAUX

Mr. Chairman, I commend you for taking the lead on this important issue and calling for these two days of hearings. Of the wide range of issues that we have studied in this Committee—preserving Social Security, strengthening Medicare, protecting consumers against fraud, to name a few—none are more important than protecting the welfare of our most vulnerable citizens. At today's hearing, we will hear stories of what can happen in nursing facilities when safeguards don't work, when they aren't carried out, or—worst of all—when people just don't care.

I join you in making it clear to nursing home residents and employees, to policymakers in state and federal government, and all Americans, that this indeed is an important issue, one that deserves a close examination. Our goal, Mr. Chairman, must be to find solutions to the problems we will hear about today—and find them quickly.

Today we will hear testimony from those who have been victimized by an ineffective system. Several of our witnesses traveled great distances to tell their stories, and I want to commend them for their efforts and thank them for sharing their testimonies.

Before we hear about some upsetting experiences our witnesses have endured, I would like to recognize the efforts of President Bill Clinton and Donna Shalala, the Secretary of Health and Human Services, who last week answered the Committee's call to address these problems. The initiatives the Administration announced, which include increasing inspections of nursing facilities that are repeat offenders and posting inspection results on the Internet, appear to address many of the concerns we will hear about today and tomorrow. We will hear more about the Administration's plans when Mike Hash of the Health Care Financing Administration testifies tomorrow.

In fact, Mr. Chairman, I suggest that the Committee offer its expertise in this area and work together with the Administration, advocates, and representatives of the industry to ensure that our common goal, protecting vulnerable and sick citizens, is met successfully and soon.

Today, we will hear about cases—bad cases—that took place in California's nursing homes. At tomorrow's hearing, we will learn how prevalent these problems are. The General Accounting Office, which did a study for the Chairman and me, will report that the current nursing home inspection process may not be doing what it was intended to do: protect residents against harm and neglect. Particularly troublesome is that in some cases state surveyors missed problems that affected the safety and health of nursing home residents, and that even when such problems were identified, enforcement actions did not necessarily ensure that the problems were corrected and did not recur. Any oversight system that lets that happen must be fixed.

We also will be talking about solutions tomorrow. I look forward to hearing from HCFA to learn more about the Administration's plans. I also look forward to hear-

ing from our industry representatives to hear about what they are doing now to help their members avoid these problems.

Mr. Chairman, this unfortunately is not the first time we have heard about problems of this sort. As the result of horrible conditions in some facilities, in December of 1987 the Congress enacted a nursing home reform law that was supposed to correct weaknesses in oversight of nursing facilities. Congressional action was prompted, in part, by an Institute of Medicine report. One of this report's conclusions's was that the states generally concentrated on helping facilities to improve their performance, rather than enforcing certification standards. Another finding was that state survey agencies lacked formal enforcement procedures and guidelines.

Nearly a decade later, on July 1, 1995, the Health Care Financing Administration's final rules for the new law became effective. Mr. Chairman, this hearing, in general, is about the effectiveness of these rules, how states are implementing HCFA's nursing home regulations and guidelines, and to what extent HCFA is overseeing the activities of the states.

But, this is the sort of discussion I expect we will have tomorrow, when we will have HCFA, the GAO, and representatives of the industry here. Today is reserved, rightly so, to hear what happens when the system does not work. Mr. Chairman, I again commend you for taking the lead on this issue, and I look forward to working with you, the Administration, resident advocates, and representatives of the industry to ensure that we never have to have a hearing of this kind again.

The CHAIRMAN. Thank you, Senator Breaux, not only for being here today and for your testimony, but for the cooperation of you and your staff during the last year in getting this all together.

Senator Kohl and then Senator Burns in that order because of arrival.

STATEMENT OF SENATOR HERB KOHL

Senator KOHL. Thank you very much, Mr. Chairman. And, of course, we thank all of the witnesses who have agreed to appear before this committee to discuss this very disturbing issue.

Before we turn to the bureaucratic failures and legal deficiencies that cause the problems we are here to discuss today, I want to take a moment to state clearly that what we are talking about today is state-sanctioned elder abuse. We are talking about Federal funds going to nursing homes, where older Americans are constantly, and very often, being hurt, starved, shamed, and neglected. We should stop for at least a minute and feel very badly, not only that this sort of abuse exists in our country, but that we have let taxpayer dollars fund it.

The Federal Government spends $32.6 billion annually through Medicare and Medicaid on nursing homes throughout our country, and that is 50 percent of all the spending on nursing homes.

There is a national system in place to ensure quality and careful care in nursing homes. Our hearings today and tomorrow will demonstrate that that system is not working. Our hearings will clearly show that there is not adequate inspection and follow-up in nursing homes and, as a result of these hearings, I hope we will strengthen our oversight to enforce a clear standard for nursing homes: Do a good job of caring for your charges, or we will put you out of business. The Federal Government has this power and the responsibility to do just that.

I do want to acknowledge, of course, that many nursing homes, if not most nursing home, in Wisconsin and across our country, are doing a terrific job in providing care to patients. They should be commended for the quality care they provide to some of the most vulnerable people in our country. But we need to do a better job,

and Senators on this committee have been working hard on this issue.

Last summer we introduced legislation to create a national registry of abusive health care workers and require criminal background checks on perspective employees. During consideration of the budget, we put the Senate on record in favor of creating such a background check system. At our request, President Clinton included in his budget increased funding for nursing home inspections, and we have followed up by requesting this additional funding in appropriations.

Just last week we passed an amendment that authorized nursing homes and home health agencies to use the FBI criminal background check system. But we cannot stop here. The testimony that we will hear today and tomorrow will clearly demonstrate that Congress must take this issue more seriously.

Last week, President Clinton called for action to clean up this system. This week, Senator Reid and I will introduce the Administration's reform legislation in the Senate. This legislation is modeled from our original bill. Together with tightened enforcement of existing nursing home standards, I believe this legislation will go a long way toward protecting patients.

Again, I am pleased that Senator Grassley has called this hearing. Before we cross that bridge to the next century, that we have all heard so much, we must make sure that we treat the people that brought us this far with the dignity, the care, and the respect that they deserve.

Thank you, Mr. Chairman.

[The prepared statement of Senator Kohl follows:]

PREPARED STATEMENT OF SENATOR HERB KOHL

Thank you, Mr. Chairman. And I thank all of the witnesses who have agreed to appear before this Committee to discuss this disturbing issue.

Before we turn to the bureaucratic failures and legal deficiencies that cause the problems we are here to discuss, I want to take one moment to state clearly what we are talking about today: state sanctioned elder abuse. We are talking about federal funds going to nursing homes where older Americans—our mothers and fathers—are hurt, starved, shamed, and neglected. We are talking about federal funds going to institutions that are making some people's last days hell on earth.

We should stop one minute and feel the shame of this. We should stop one minute and be ashamed—not only that this sort of abuse exists in our country—but that we have let taxpayer dollars fund it.

I do want to acknowledge that many nursing homes in Wisconsin and around the nation are doing a terrific job providing care to elderly and disabled patients. They should be commended for the quality care they provide to some of the most vulnerable people in our country.

However, I am appalled by the increasing number of stories of patient abuse, neglect, and mistreatment. Our elderly citizens have made our country what it is today—they should be treasured, not subjected to substandard care and dangerous facilities.

While I am glad that the Senate Aging Committee is shedding light on this problem today, I regret that it is still necessary to talk about it. It should not be necessary to talk about patients dying from malnutrition or dehydration. We should not have to talk about shoddy enforcement of nursing home safety laws. Nor should we have to worry about elderly and disabled patients being abused by the people who are supposed to care for them.

We should be doing a better job in protecting our nation's elderly and disabled patients. Senator Reid and I have been working hard on this issue, and although there is still much work to do, we have made some significant progress:

Last summer, we introduced legislation to create a national registry of abusive health care workers and require criminal background checks on prospective employ-

ees. During consideration of the Senate Budget Resolution, we included an amendment that put the Senate on record in favor of creating such a background check system. At our request, President Clinton included in his budget increased funding for nursing home inspections, and we have followed up by requesting this additional funding in the Senate Labor, HHS Appropriations bill. And just last week, we included an amendment in the Commerce, Justice, State Appropriations bill that authorized nursing homes and home health agencies to utilize the FBI criminal background check system if they so choose.

But we cannot stop here. The testimony that we will hear today and tomorrow will clearly demonstrate that Congress must take this issue seriously, and take action now. Last week, President Clinton called for both legislative and administrative action to clean up this system. This week, Senator Reid and I will introduce the Administration's reform legislation in the Senate. This legislation is modeled from our original bill. It will require that all prospective nursing home employees have a criminal background check, authorize additional staff to be trained to feed nursing home patients, and reauthorize the Nation's Ombudsman program to continue to serve as an advocate for nursing home residents. Together with tightened enforcement of existing nursing home standards, I believe this legislation will go a long way toward protecting patients.

Again, I am pleased that Senator Grassley has called this hearing to focus on the serious deficiencies in nursing home safety enforcement. But I am saddened and ashamed that there is a need to have this discussion. Before we cross that bridge to the next century that we have all heard so much about, we must make sure we treat the people that brought us this far with the dignity, care, and respect they deserve.

The CHAIRMAN. Thank you, Senator Kohl. I am happy to be a cosponsor of your bill and work with you. As I recall, we are having a hearing on your legislation in September, I believe.

Senator Burns.

STATEMENT OF SENATOR CONRAD BURNS

Senator BURNS. Thank you very much, Senator Grassley, Mr. Chairman, and thank you for calling this hearing.

Looking over the information that we have today, it sounds like California has been sort of singled out, but I will assure you that the problem just is not in California alone. It is of a national concern all of the way from our small rural towns and areas up to the more urbanized areas of this country.

I am going to submit my statement, but I want to bring up I just lost my mother a year ago right now, and she spent a 1½ in a nursing home. She had a stroke, and she was 88, and lost her eyes. And every time that I went to the nursing home I will tell you, those of you who manage nursing homes here, that I did not visit her that she was not thirsty. It does not sound like much, does it? But I will tell you little things that lead to larger things are very prevalent among nursing homes. For the most part, I think my mother received very good care, but she was always thirsty.

We hire these dieticians that have college degrees that run from here to there and do not know "sicum" about food. That is part of our problem. And people that work in government bureaucracies, I have never seen a government bureaucracy that ever had an ounce of compassion.

So I think there are enough faults to be passed around to everybody, and maybe we ought to go to—it weighed on me—maybe we ought to go back to doing it the old way when grandma and grandpa stayed at home, and we took care of grandpa and grandma until their days were over. That is the way it was done in the old days. That is what is going to happen to me because I am not going to one of them things. I just am not going.

But, nonetheless, it is the simple necessities of life that are denied in many cases, maybe not denied, but overlooked. I would say we spent $31 million in Federal and State funds in California alone for a survey and certification of nursing homes—$31 million—that buys a lot of water, a lot of water—to find out that the simple necessities, the very simple ones are either overlooked or disregarded when it comes to care of a human being.

Now, of course, Senator Grassley and I, we come from agricultural and farm backgrounds. We look upon those things a little bit different. But maybe we should recommend to our American citizens that grandma and grandpa, as long as they can stay at home and we can take care of them, maybe we ought to. That is a very viable option, as far as I am concerned.

So I want to hear the witnesses today. I appreciate your calling this. We can pass all kinds of laws. We can get up here and feel good about ourselves, and we can pass these laws, and they are not worth much more than "sicum" either.

Until America wakes up and starts feeling some real compassion and does some real things for real people than this superficial or trying to come here in this place, this 17-square miles of logic-free environment, and think that we have solved the problem, when we will not. It has to start at the bottom, and it has to start with communities, and I will always believe that. Strong communities usually demand strong standards.

So that is my statement, and thank you very much for holding these hearings.

[The prepared statement of Senator Burns follow along with prepared statement of Senator Hagel:]

PREPARED STATEMENT OF SENATOR CONRAD BURNS

Thank you, Chairman Grassley. I appreciate your calling this important hearing.

We are about to hear some shocking and disturbing allegations of poor care and neglect which resulted in mental and physical harm to nursing home patients.

Despite stringent Federal and State survey and certification programs for nursing homes, severe problems persist. Today we will seek to pinpoint how the system failed to protect these patients.

Over $31 million in Federal and State funds were spent in California in 1997 on survey and certification of nursing homes. This amounts to $22,317 per nursing home on measures designed to protect patients and ensure quality care. Where did the system fail? Is the Federal Government meeting its requirement to "look behind" surveys in California? If it is doing the required "look behinds," has the Federal Government identified problems with the way the state surveys facilities? If so, what has been done to correct the problems?

Every nursing home patient is supposed to be in the care of an attending physician. Why didn't the physician recognize poor care in these cases?

The survey and certification process is not working in California. Is this simply and enforcement problem? Should Congress consider private accreditation, such as through the Joint Commission on the Accreditation of Health Care Organizations? How many facilities in California are JCAHO accredited?

These are just some questions we need to answer during this hearing. We also need to do more research in the rest of the states to see how widespread these types of problems are. Finally, we need to ensure that the survey process focuses on problem facilities so that their practices are immediately corrected or the facility is shut down. I would caution against applying new layers of regulations on those nursing homes which are doing a good job caring for their parents.

Thank you Chairman Grassley.

PREPARED STATEMENT OF SENATOR CHUCK HAGEL

Good afternoon, Mr. Chairman. Thank you for calling these timely and important hearings. .

Our hearings today and tomorrow will take a critical look at the quality of nursing home care in the state of California and seek to draw general conclusions about the challenges we face nationwide in providing the quality of care that our seniors deserve. It is important to note that the findings released today only address severe quality of care problems in California nursing home industry.

As the General Accounting Office report released today indicates and as we will hear in witness testimony, Federal nursing home guidelines are not being effectively enforced in our most populous state. This is a critical problem for our nursing home population and their families.

And this is a problem we must fix immediately. If we do not substantially improve the infrastructure we have in place to enforce Federal guidelines today, the coming explosion in our nation's nursing home population will make these problems all the more difficult to fix.

A we have often heard in this committee, the aging of the baby boom generation, particularly as its members reach age 85 and older, will cause a dramatic increase in the number of people needing long-term care services. The challenge of affordably meeting these long-term care needs is becoming more pressing for individuals who are now preparing for retirement, their families and for policy makers. Indeed, paying for the long term care needs of the baby boom generation will be one of the great financial challenges we will face as a nation in the next century. Currently, the average annual cost of nursing care is $40,000 per patient per year.

The financial and emotional realities of placement in a nursing home present families with enough of a challenge without the fear that nursing home care is substandard or even dangerous.

I find it ironic that, at a time when we are learning about the deficiencies in the Health Care Financing Administration's (HCFA's) current ability to enforce Federal standards and ensure quality of care for our nations seniors, some in Congress are proposing that we expand the government's role in our health care system. How can we expect our Federal agencies to enforce numerous new Federal health care mandates when they are struggling to live up to their current responsibilities and in HCFA's case, falling far short?

But these hearings are not just about problems—they are primarily about finding solutions. I look forward to hearing about ways we can correct this situation in California and improve elsewhere in our nation in order to ensure current Federal guidelines on nursing home quality are effectively enforced.

Thank you, Mr. Chairman.

The CHAIRMAN. I thank each of my colleagues for being here with us. I am going to call our first panel now. Would you please come up while I am introducing you.

Our first panel consists of three individuals, two of whom are with us, who have experienced, firsthand, neglect occurring in California nursing homes. They will describe the devastating effect of substandard nursing home care that touched each of their lives. They are Mrs. Ellen Curzon, Mr. John Davis, and Ms. Leslie Oliva.

Our first panelist is Mrs. Curzon. She is here to tell her husband's story. Mr. Curzon had a series of strokes. Following his second stroke, Mrs. Curzon could no longer take care of her husband at home by herself. She had to admit him to a nursing home. Mr. Curzon entered the first nursing home in pretty good physical shape, I am told, and was able to get around well with his walker.

Sad, though, Mr. Curzon's condition progressively deteriorated leading to his death after only 6 weeks in two different nursing homes. Mrs. Curzon hopes that, in sharing these painful memories with us, she can somehow help others avoid what happened to her husband.

Our second witness is John Davis, and due to his poor health, Mr. Davis will be testifying today by way of videotaped interview. Mr. Davis is a decorated World War II veteran, currently residing

in California. He was injured in an accident in 1989. Following two surgeries and 2 months' stay in the hospital, his odyssey began. He will tell the story of how he was shuffled from one nursing home to another and was treated progressively worse as his health rapidly deteriorated.

Then we have Leslie Oliva, and she is here to tell her mother's story. She lost her mother, Marie Espinoza, this past March, after 3 years and three different California nursing homes. She feels that the quality of care that her mother received during her stay in these three nursing homes was questionable at best. She is going to report to us how she reported repeatedly her mother's deteriorating health and the poor care she was receiving to both the ombudsman and the state licensing office because she received no responses from them.

We will start with you, Mrs. Curzon.

STATEMENT OF ELLEN CURZON, LAKESIDE CA

Ms. CURZON. If I may, I will read this testimony. My name is Ellen Curzon.

The CHAIRMAN. Pull the microphone down, and maybe staff can help center it. It should be centered right in front of your mouth.

Ms. CURZON. How is that? Can you hear me?

The CHAIRMAN. Yes.

Ms. CURZON. Senator Grassley, I wish to thank you and your committee for the opportunity to share my family's experience with convalescent homes and elder abuse.

My husband, Oswald Curzon, was a mail carrier for the U.S. Postal Service for 30 years. He developed a chronic impairment of the lower back as a result of carrying the mail bag for so long, and by the time he was in his late seventies, this impairment had forced him to use a cane when moving around.

In July 1991, my husband was 84. He suffered a stroke which did not paralyze him, but caused weakness and some dementia. At that time, I was 77 and in reasonably good health, so was able to care for him at home for the next 2½ years.

In December 1993, he suffered another, more severe stroke, which again did not result in paralysis, but did cause further weakness and more severe dementia.

My husband was 6 feet tall and weighed 185 pounds. I am 5 foot 4 inches and weigh 120 pounds. He required constant care. He was legally blind, so had to be helped with eating, bathing, moving about the house, using the bathroom, and being put to bed. It became a 36-hour day.

Finally, in January 1994, my family and I made the decision to place my husband in a convalescent home. This was a traumatic decision for all of us, but we knew that physically I was no longer able to cope with caring for him at home. It was conceivable that my husband could fall, with a greater probability that he would fall on me, and I would be unable to summon help.

Making the decision was easy compared to finding a bed. We had a pension from the Postal Service and the minimum Social Security, which totaled less than $2,000 per month. So I began visiting convalescent homes in the vicinity. The average cost of convalescent nursing homes in San Diego County is $3,000 per month. So

I had to apply for MediCal/Medicare funding. I also learned that under State/Federal funding only a certain number of beds are set aside for patients.

The search for a suitable place for my husband was lengthy and exhausting. When I finally found a convalescent home which, on the surface, looked clean and decent, I placed him there on January 25, 1994. At that time, my husband was in good health. He had insulin-controlled diabetes and was legally blind, but he was able to eat and truly enjoyed his food. He had no decubitus ulcers or any other infection.

I visited my husband every day but two in the 2 months he was in this facility. In 6½ weeks he lost 35 pounds, developed decubitus ulcers on the buttocks and became so dehydrated he flinched when touched. He was also bruised on the arms from bed restraints.

Due to his weight loss, his dentures no longer fit correctly and were causing sores in his mouth, which made it extremely difficult for him to chew. His lower denture was then lost, so he was being fed pureed food, which was so unappetizing he would not eat it.

Every single day I had to literally hunt for someone to change him because when I arrived about 10 a.m. he was always wet. One day he was in bed when I got there and had evidently been given an enema. The bed was full of the enema water and the feces, and it appeared as though he had been lying in this for hours.

Another day I asked that a urine sample be collected and sent to the lab because my husband had a history of urinary tract infections. The sample was secured and remained on the shelf behind the head nurse's desk for 2 days. Of course, by that time the sample was useless and was never sent. I found this out in the course of the investigation after my husband's death.

During the period of time my husband was in this facility, I called the doctor to whom he was assigned twice and went to his office on two different occasions to complain about the lack of care he was receiving and how he was, obviously, losing weight. His regular physician did not practice in the area of this nursing home, so we had to accept a doctor assigned to the facility.

I never succeeded in either seeing or talking with the doctor until my husband became so alarmingly ill that I called frantically one morning and demanded that he be placed in a hospital. Twelve hours later he was finally admitted to the hospital. Due to severe dehydration, his kidneys were failing, and he had lost the ability to swallow, so a feeding tube had to be inserted into this abdomen.

While Mr. Curzon was still in the nursing home, a representative of the California State Board of Licensing took me aside one day and asked if I was satisfied with the quality of care in this facility. She said she had been investigating and checking on this facility for several years, and that they had been cited and fined many, many times. She also told me the location of the office, which keeps a record available to the public of citations and fines levied against all nursing and convalescent homes.

I told her my whole family was indeed unhappy with the care, and that I would go to look at those records. The records I saw indicated that this particular facility had been cited and fined enumerable times. The policy appeared to be: pay the fine, hire more personnel, receive an OK from the state investigators, and then im-

mediately reduce the number of staff to the former level, a level of totally inadequate care. This happened many times.

The records on file at the State Licensing Bureau indicated this facility has received citations and been fined so many times over a period of years that it is shocking.

When my husband's condition was finally stabilized after 10 days in the hospital, I found another convalescent home which had a bed available for a Medicare/MediCal patient. The care he received in this facility was so compassionate and professional that I firmly believed my husband would have lived longer and, certainly, would never have suffered the agony he did if I had been able to place him there at the outset.

Because convalescent nursing homes can represent large profit margins, some unscrupulous owners/operators hire too few, often untrained personnel who are unable to provide even a minimum of basic care for patients.

Unfortunately, my husband's experience is far from unusual. If by giving this testimony I can assist in reducing or eliminating some of the horrors my husband suffered and my family witnessed, then my time and yours will not have been wasted.

[The prepared statement of Ms. Curzon follows:

TESTIMONY OF ELLEN CURZON
LAKESIDE, CALIFORNIA
July 1, 1998
TO SENATE SPECIAL COMMITTEE ON AGING

Senator Grassley, I wish to thank you and your committee for the opportunity to share my family's experience with convalescent homes and elder abuse.

My husband, Oswald Curzon, was a mail carrier for the U.S. Postal Service for thirty years. He developed a chronic impairment of the lower back as a result of carrying a mail bag for so long and by the time he was in his late seventies, this impairment had forced him to use a cane when moving around.

In July 1991 when my husband was 84, he suffered a stroke which did not paralyze him but caused weakness and some dementia. At that time I was 77 and in reasonably good health so was able to care for him at home for the next two and one-half years.

In December 1993 he suffered another, more severe stroke, which again did not result in paralysis but did cause further weakness and more severe dementia.

My husband was 6 feet tall and weighed 185 pounds. I am 5 feet 4 inches tall and weigh 120 pounds. He required constant care. He was legally blind so had to be helped with eating, bathing, moving about the house, using the bathroom and being put to bed. It became a 36-hour day.

Finally, in January 1994, my family and I made the decision to place my husband in a convalescent home. This was a traumatic decision for all of us but we knew that physically I was no longer able to cope with caring for him at home. It was conceivable that my husband could fall, with a greater probability that he would fall on me, and that I would be unable to summon help.

Making the decision was easy compared to finding a bed. We had a pension from the Postal Service and the minimum in Social Security which totaled less than $2,000.00 per month. So I began visiting convalescent homes in the vicinity.

The average cost of convalescent/nursing home care in San Diego County is $3,000.00 per month so I applied for Medical/Medicare funding. I also learned that convalescent/nursing homes have only a small number of beds set aside for patients under state/federal funding. The search for a suitable place for my husband was lengthy and exhausting. When I finally found a convalescent home, which on the surface looked decent and clean, I placed him there on January 25, 1994.

At that time my husband was in good health. He had insulin-controlled diabetes and was legally blind but he was able to eat and truly enjoyed his food. He had no decubitus ulcers or other infections of any kind.

I visited my husband every day but two in the two months he was in this facility. In six ½ weeks he lost 35 pounds, developed decubitus ulcers on the buttocks and became so dehydrated he flinched when touched. He was also bruised on the arms from bed restraints.

Due to his weight loss, his dentures no longer fit correctly and were causing sores in his mouth which made it extremely difficult for him to chew. His lower denture was then "lost" so he was being fed pureed food which was so unappetizing he wouldn't eat it.

Every single day I had to literally hunt for someone to change him because when I would arrive about 10:00 a.m. he was always wet. One day he was in bed when I got there and had evidently been given an enema. The bed was full of the enema water and feces and it appeared as though he had been lying in this for hours.

Another day I asked that a urine sample be collected and sent to the lab because my husband had a history of urinary tract infections. The sample was secured and remained on the shelf behind the head nurse's desk for two days. Of course, by that time the sample was useless and was never sent. I found this out in the course of the investigation after my husband's death.

During the period of time my husband was in this facility, I called the doctor to whom he was assigned twice and went to his office on two different occasions to complain about the lack of care he was receiving and how he was obviously losing weight. (His regular physician did not practice in this area of the county so we had to accept the doctor assigned by the facility).

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personnel, receive an O.K. from the state investigators, and then immediately reduce the number of staff to the former level---a level of totally inadequate care. This happened over and over again. The records on file at the state licensing bureau indicated this facility has received citations and been fined so many times over a period of years it is shocking.

When my husband's condition was finally stabilized, after ten days in the hospital, I found another convalescent home which had a bed available for a Medical/Medicare-funded patient. The care he received in this facility was so compassionate and professional that I firmly believe my husband would have lived longer and certainly would never have suffered the agony he did if I had been able to place him there at the outset.

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Unfortunately, my husband's experience is far from unusual. If by giving this testimony I can assist in reducing or eliminating some of the horrors my husband suffered, and my family witnessed, then my time and yours will not have been wasted.

The CHAIRMAN. Were you finished?

Ms. CURZON. Yes.

The CHAIRMAN. I thought maybe the lights bothered you here, and if you needed more time, I wanted to give it to you. I forgot to introduce a picture of your deceased husband. His picture is the person here in the tuxedo. So I want everybody in the audience to know that this is the loved one of Mrs. Curzon.

Before Ms. Oliva goes ahead, we are going to have Mr. Davis by videotape now. So would the staff turn on the videotape.

VIDEOTAPED STATEMENT OF JOHN DAVIS

Mr. DAVIS. It took about 3 months for them to get it all found out and do another surgery, and then I started going into one rest home after another. I went into—[blank]—for 3 months. I had quite a bit of therapy, and that did not work out. The care there was excellent, and they kicked me out when I did not gain enough. Then I went to a place in Santa Cruz, and that was the worst hell-hole you ever went into.

INTERVIEWER. Was it a nursing home, John?

Mr. DAVIS. It was a nursing home, and it smelled when you walked in, and it did hit you right in the face all of the way down. Their main diet was Spanish rice, and the care was absent. You would lie there for hours if you wanted something, and they would set your food down, say, "Here is your breakfast," and go on by, and about an hour later somebody would come by, say, you are not hungry, pick up the plate and take it away.

INTERVIEWER. With you never eating?

Mr. DAVIS. And they never offered to help you or feed you or anything else. They never gave you a bath. They would come in and say there is not any hot water today, and I would say, "Well, try turning it on. We will use the cold." That is about the way it went all the time I was there for 2 months.

I went into the VA for 3 months, and that was the best place I have ever been. The care was good, the food was good, and your doctors cared. If you did not get the attention, they were right on it.

Then they sent me to—[blank]—and that was a pig-pen-and-a-half. There was two other guys in that room when I came in. One of them was covered with bedsores and had been there for 9 years, neglect, and filth, and the other one would get up and pee on the floor and do the continuous diarrhea all the time, and it was not cleaned up much.

I was there about 3 months, and I went back to the VA until November 1990, and in 1990 I went to—[blank]—convalescent home in—[blank]—and that was an eye-opener. They would never come and get you up. If you rang a bell and had to go to the bathroom, they would just leave you there until you went, and then maybe they would clean you up in an hour or two, or maybe they would do it after lunch. The food was the worst of anyplace, and the only way I survived was Elizabeth and her friends brought me nuts, and graham crackers, and Fig Newtons, and stuff like that, that I sometimes shared with the other two.

I was covered at the end of the time from my neck down with scabies. They would not put anything on it. I got out with Liz one

day and went to the VA and got the medicine of Kwell to put on it. They gave us a big bottle. They would not even put it on because their doctors had not prescribed it. Elizabeth and one of the attendants helped her, and they put that stuff on me.

A few days after that I left that drastic—oh, they let Tommy choke to death.

INTERVIEWER. Who was Tommy?

Mr. DAVIS. He was a guy in the room at—[blank]—and he used to lay bricks on the freeway, and he had a problem of choking if he was too flat when he ate. And they moved him into a room by himself and just let him choke to death because I always hollered loud enough that somebody would come and do something about it.

INTERVIEWER. When he was choking, you mean you would get some help in there for him when he was choking?

Mr. DAVIS. Yeah. And I told his wife, and she did not, she said, "Ah, they would not do anything like that." Well, the next day he was dead, and that proved I was right.

A few days later Liz got me out of there.

INTERVIEWER. While you were in that nursing home, or while you were in the two nursing homes that you spoke about, what kind of treatment did the elderly and the disabled in there get, besides you? What kind of treatment was being given?

Mr. DAVIS. All of them got about the same amount of care—lack of it, I should say.

INTERVIEWER. What about staffing, how was the staffing there?

Mr. DAVIS. Well, the staff was under. A lot of them could not even speak English, did not understand what they were told to do, and by the time you got one of them so they could handle you, they would send them someplace else and give them about ten patients, and you would start in trying to get another one to help you.

INTERVIEWER. When the patients came in there, the older people came in there, they were walking most of them or——

Mr. DAVIS. Some of them.

INTERVIEWER [continuing]. Some of them, and——

Mr. DAVIS. But a lot of them are in wheelchairs.

INTERVIEWER. How long did it take before you started seeing deterioration set in on them?

Mr. DAVIS. Well, not very long because pretty soon they could not get out of bed.

INTERVIEWER. What kind of help did you get in your complaints to the State, and were you aware when the State was coming in? Did you know?

Mr. DAVIS. You would know half-a-day ahead of time. Everybody would go to work about 6 o'clock in the morning cleaning up, mopping, polishing the hallways, and everybody they could get a bath that day, and it really would not stink because they would open all the windows and air the place out.

INTERVIEWER. And so you feel like there was prior notification of their inspections.

Mr. DAVIS. Oh, yes. And when I filed that one complaint with the ombudsman, the manager came in there and raved and ranted at me for about a half-an-hour.

INTERVIEWER. Were you intimidated by this? Did you feel threatened?

Mr. DAVIS. No. I hollered louder than she did.

INTERVIEWER. Good for you. Good for you.

Mr. DAVIS. I was in a total of three of these nursing homes in California, and every one of them were pig pens most of the time, and the only time that they ever got cleaned up and you got any care was if they knew ahead of time that somebody was coming, like on holiday, they would give you a halfway decent meat, meal. The rest of the time they did not care whether you got fed or not. The food could be cold, and if you did not get any or you could not reach it, that is your hard luck.

ELIZABETH MEANS. And one time we looked in the bathroom, and there was his toothbrush on top of the rag that they had used on his bottom. So you just, even if you are there every day, you just cannot monitor all of the things that go on that can be life-threatening for someone who—well, he is in his right mind. If he were not, I guess it would not make any difference, but he knew all of these thing were happening. It was terribly frustrating.

Mr. DAVIS. And just hopeless. You get that hopeless feeling, and you just about give up.

[End of Videotape.]

The CHAIRMAN. I want to thank Mr. Davis for participating long distance the way he has for our hearing. Obviously, the members will not be able to ask him any questions, but we appreciate very much his participation.

Ms. Oliva.

STATEMENT OF LESLIE OLIVA, WHITTIER, CA

Ms. OLIVA. Senator Grassley, I thank you for inviting me to testify at today's hearing and to share my family's experience with the quality of care in the California nursing homes.

Being able to share our story, so that it might help someone else, is part of mine and my family's healing process. My name is Leslie Oliva, and I live in Whittier, CA, with my family. I have been married for over 18 years. I have two daughters, and two sons, and five grandchildren. I come from a family of seven, and I am the third-born child. I work full-time as an inside sales representative for the aerospace industry.

My mother passed away in March 1998 after having Huntington's Corea disease for approximately 13 years. She was 56 years old when she passed away. As you view the pictures I have taken of my mother at the nursing homes, you can tell she has experienced beatings, malnutrition, dehydration and neglect. It was a very awful experience that we all suffered.

I was my mother's caregiver, and I know how physical and emotional my mother's illness has taken a toll on my life, as well as the lives of our family.

In April 1995, my mother was placed in Nursing Home No. 1. During the 6 months while she was at Nursing Home No. 1, she started experiencing heavy bruising. Bed sores had started early in July. One day, while changing my mother's clothes, my mother started complaining of awful pain in her lower bottom area. I looked at it, and I was surprised to see the terrible wound she had had on her lower bottom. It had a very bad, foul smell, and I called in the nurse.

The head nurse came in, and she told me my mother had fallen from the bed and broke her pelvic bone, and that a small bed sore had developed. It was my first notification of this, and it was not a very small wound.

I asked the nurse to give my mother some juice and some other items for her to have that she was missing—

The CHAIRMAN. You take your time, Ms. Oliva. If you need some time to get your composure, just take whatever time you need.

Ms. OLIVA. During the time my mother had been at Nursing Home No. 1, she was showing up with very bad bruising. Her body weight was dropping. She was always begging for water and food. She always seemed to be dying of thirst.

The times that I had come to visit my mother I was always bringing her food, juices, and other items that she was neglecting, that the nursing home was not providing, and taking from her.

I noticed her bed sores were getting worse, so I took pictures. I asked the head nurse if the doctors had come to see her. They said my mother sees him only once a month and they had told me that during his visits she was really not being examined.

In regards to the bed sores that originally occurred at Nursing Home No. 1, my mother should have never had bed sores or should have suffered like she did. The bed sores got so bad that it ate into her back tailbone. She ended up having a bone-scrape surgery. She was in surgery for about 4½ hours, but the infection kept getting worse. The last nursing home did not put my mother into isolation.

After being hospitalized for 2½ weeks, my mother was sent to Nursing Home No. 3, which she had lived there for 2½ months before she passed away.

While at Nursing Home No. 3, I requested bumper pads for her. I visited her every day after work up until February 5, when I was paged by a male nurse and told me my mom was sent to Riverside General Hospital (RGH) due to a low blood count and that I should not worry. I then went to RGH and found out that my mom had gotten a terrible ulcer from the bed sores. They asked if she could have a feeding tube, since her weight had dropped. The surgeon assured me at that moment that my mom would be fine.

After the surgery, they sent her back to Nursing Home No. 3. Marlene from Nursing Home No. 3 called me and apologized for not placing my mother in isolation. This was about the middle of February 1998. Later, Marlene called me at work again and said, "Your mom pulled out the feeding tube," and had told me not to worry. She had told me that the doctors were on the way to put the feeding tube back in.

She must have called me on a Wednesday. I went to see my mother and checked her feeding tube. It was completely gone. The only thing that was there was a large band-aid. I asked my mom if she was in any pain, and she had said yes. I asked my mother if she had pulled out the feeding tube and she replied with, no. I then groomed my mother and cleaned her up, and I stayed with her for about 2½ hours. She was still not in isolation.

A week had went by, so I went by, and I had noticed that the feeding tube was back in my mother. On March 30, 1998, at about 10:15 a.m., Marlene from Nursing Home No. 3 had called me and she said, "Your mother choked on food, and she is getting oxygen

by the paramedics." She asked me not to worry. She had told me and assured me that everything was OK. I asked Marlene if my mother had passed away or if she died. She replied with, no.

I asked her how she could have choked when she had a feeding tube. There was no logical explanation. I asked Marlene what was my mother doing with food when she had a feeding tube. While going to Palm Terrace, they assured me that my mother was OK, and once I reached the last nursing home, they had told me that the paramedics had taken my mother down to the Kaiser Riverside.

Once on arrival, I met with the doctor, and he had told me that my mother had passed away. I asked him how could this have happened when I was just assured that my mother was alive and that she wasn't dead? While waiting for my family, I started to investigate my mother's body. I noticed scratches along her chest, where the tube was, and her chest was really inflamed. Her right thumbnail was ripped off, completely off, and her eye was gray. Apparently, she went blind.

The feeding tube was up in the chest toward the rib cage. The last time my family and I had saw the tube, it was in a totally different place, closer to the stomach.

On March 31, my husband I went to Nursing Home No. 3. I asked how my mother had passed away and how come she was choking on food when she had a feeding tube. The administrator could not answer me. The administrator said to me that she was sorry about my mother. I asked her for my mother's records and asked her who changed the feeding tube.

The administrator said that they had, and the nursing staff and the helpers. She had told me, "As you know, Leslie, your mother pulled the tube out." I told her when I came to see my mother the feeding tube was completely gone. The administrator said, "You are right, but we had put it back in," so what was I trying to get to? They had told me that my mother did it and did not need to be hospitalized, and that was medical procedures, and that they had a trained staff to handle any medical procedure.

I then asked for my mother's records. The administrator would not give me the records. She had asked me to leave and to come back in a couple of days. I had told them that I was going to stay until the records were all made copies of. She had then had an assistant bring the records out. They started making copies. The administrator had pulled out three to four pages. She had told me and advised me that the pages that were pulled out did not pertain to my mother.

I asked who was there when my mother was dying, and she said she was. At about 7:15 a.m. she had told me she saw my mother and she looked fine. About 8:30 a.m. she said, "Your mother looked happy, but she was cold, and she was tired, and she wanted to sleep."

Then the administrator stopped. She said nothing. I asked where did my mother get the food? How could she have choked on the food when she supposedly had a feeding tube and why did you and your staff tell me my mother was OK and still alive?

The administrator asked why I was asking so many questions, and I said my family needs to know the truth.

In regard to the bed sores, bed sores that originally occurred at Nursing Home No. 1, my mother should never have had these sores, nor should she have ever suffered like she did. The bed sores got so bad that it ate into her back pelvic bone.

I think Congress and the President need to work on safer nursing homes for our parents. We, the people from the State of California, are not safe. As we get older, our lives depend on caregivers, doctors, nursing facilities. Our lives and the lives of our parents are precious, and I am asking you, Congress, and the President to stop and see the ugly abuse, the neglect, the malnutrition that our families, our parents, our mothers, and our fathers of the Nation are experiencing, and I ask that you please stop and look and get a lot more involved. Our parents, our families, and our future generations do not need to suffer this way.

The nursing facilities are stealing our hard-working money and are not providing the right care-giving to our families. I think, and I believe in my heart and the hearts of the nation, that our families should have the same equal rights. Abuse towards our parents and our elderly should be treated the same way that child abuse is.

Thank you.

[The prepared statement of Ms. Oliva follows:]

Testimony of Leslie Oliva
For Maria Elena Espinoza
Whittier, California

Betrayal: The quality of Care in California Nursing Homes
Hearing before the United States Senate Special Committee on Aging

Senator Grassley, Chairman of the Committee - Thank you for inviting me to testify at today's hearing and to share my family's experience with the quality of care in California nursing homes. Thank you for your patience.

Being able to share our story, so that it might help someone else, is part of my and my family's healing process.

My name is Leslie Ann Oliva. I live in Whittier, California with my family. I have been married for 18 years. I have two daughters and two sons and five grandchildren - we are a family of seven children, I am the third born child. I work full-time as a sales account executive for Aerospace Government Contracts.

My mother passed away in Mach of 1998 after having Huntingtons Corea Disease for approximately 13 years. She was 56 years old when she passed away. Huntingtons Corea Disease is an inherited degenerative brain disease. A disease of both mind and body. Huntingtons usually progresses over a 10 to 25 year period. Each child of an Hd-affected parent has a 50% chance of inheriting the disorder and is said to be "at risk."

The characteristics and symptoms are difficulty in swallowing, personality changes, depression, mood swings, unsteady gait, involuntary movements, slurred speech, impaired judgment, intoxicated appearance and short-term memory deficit.

As you view the pictures I have taken of my mother, you can tell she experienced beating, malnutrition, dehydration and neglect. It was an awful experience that we all suffered. I was my mother's care giver and I know how physical and emotional my mother's illness has taken a toll on my life, as well as my children's lives. I feel that I too have been a victim of my mother's illness, being the primary care giver. It was a very stressful job and sometimes I became physically unable to continue the care giving. My mother was married for 10 years to my father.

My mother raised seven children and worked full-time and attended Fullerton College. She later obtained a B.A. degree in Machinery. She was very active in sports, loved to camp in the Sequoias, and we spent a lot of time at the beach. My mother took very good care of us and I was giving back the same care to my mother when she was alive. Finally, I was told by doctors she needed to be placed in a skilled nursing facility.

In April of 1995, my mother was placed in Orangetree Convalescent Center. During the 6 ½ months while she as at Orangetree Convalescent, she started experiencing heavy bruising. The bed sores

started in early July. One day while changing my mother's clothes, my mother said she had pain on her lower bottom area. When I looked at it, I was surprised to see a terrible wound. It had a foul smell and I called in a nurse. The head nurse that came in and she told me my mother had fallen off the bed and broke her pelvic bone and that small bed sore had developed. This was my first notification of this and it was not small.

I asked the nurse to give my mother juice, but she said my mother had enough for the day. The nurse did mention to me that my mother has not eaten her dinner or lunch, so I left to go buy my mother some fast food with one quart of cranberry juice. She acted like she was dying of thirst. Usually in my visits with my mom, she had always seemed to be starving or always begging for water. Each time I gave her something, she would grab the food or water from me. She could not wait to eat or drink. I bought some cream for the bed sores. I would clean out the wound. Each time I visited my mother, she always had a dirty diaper or dirty shirt. Her bed seemed to always smell of ammonia. My mom always cried to come home. She would hang on my arm like I was her hero.

I noticed her bed sores were getting worse, so I took pictures. I asked the head nurse if the doctor had been into see her. They said my mom sees him once a month. I never knew how my mom got the bed sores. I also noticed her weight kept dropping. Most of the time during the visits, I would see my mom always in bed and her food tray was always at the foot rest, out of her reach. The staff always said my mom did not like the food. I called the ombudsmen and State Nursing. They came out to investigate my complaint. The ombudsmen did nothing. After the complaint, the head nurse came to me while I was feeding my mom and said this is no place for your mother to be. My nurses can't watch your mother all of the time and feed her, so please take your mother out and place her in another home. The next day, I called Orangetree admissions office. I told them I would be changing homes. They asked why and I said because my mom has real ugly sores on her lower bottom and she got a black eye, plus I should not have to bring extra food and juices. I told them the food is always at the end of her bed, out of reach. I noticed this with other residents. The administrator told me just because your mother will not eat, does not mean all of our patients don't eat.

As time went by, apparently, the wound got worse, the nursing home stated to me, the infection was gone - while in January 1998, my mom was admitted to River RGH for dehydration. Dr. Chang called me and asked me if my mom was on full code. I said yes. Dr. Chang said that my mom had developed a 10 x 10 wound and it would not heal. He said my mom was probably bleeding internally and she had two blood transfusions. Dr. Chang saw no signs of lung infection, but my mother was holding a fever of 103.2 for the last week. The fever maintained at 104.2 but no lower than 101.4. She stayed in ICU. Dr. Chang and Dr. Burklgnole knew she had 350cc's of blood. Also, I had been in contact with Dr. H. Kim. He said my mom kept bleeding. Dr. Kim said he was the anesthesiologist - he stated don't worry about the surgery, your mother will be fine.

In regards to the bed sores that originally occurred at Orangetree, my mother should have never had any bed sores or should have suffered like she did. My mother ended up having major surgery. The bed sores got so bad that it ate into her back tale bone. She ended up having a bone scrape surgery. She was in surgery of 4 ½ hours but the infection kept getting worse. The last nursing home did not put my mother into isolation - after being hospitalized for 2 ½ weeks, my mother was sent to Palm

Terrace Nursing Home, which she lived there for almost 2 months. She then passed away.

After leaving Riverside General Hospital ("RGH"), after being treated for the injuries received at Extended Care, the social worker sent my mother to Palm Terrace in Riverside, 11162 Palm Terrace Road, Riverside, CA, tel: (909) 687-7330. She was admitted January 10, 1998 and died March 30, 1998.

While at Palm Terrace, I requested bumper pads for her. I visited her everyday after work - up until February 5th, when I was paged by a male nurse and told my mom was sent to RGH due to a low blood count and that I should not worry. I then went to RGH and found out that my mom had gotten a terrible ulcer from the bed sores. She needed immediate surgery and there were only two strong medications that would save her - I then okayed the surgery. They also asked if she could have a feeding tube, since her weight had dropped. The surgeon assured me that my mom would be fine, so I okayed that as well. After the surgery, they sent her back to Palm Terrace, not once did she have any bruising, but they did not protect her from infection and my mom caught a germ in her ulcer and in her lower back. Marlene from Palm Terrace called me and apologized for not placing my mom in isolation - this was about the middle of February 1998. Later Marlene called me at work again and she said your mom pulled out the feeding tube but don't worry, the doctor is on the way to put it back in.

She must have called me on a Wednesday. I went to see my mom Friday and checked her feeding tube. It was gone. The only thing there was a large band-aid. I asked my mom if it hurt, she said yes - I asked did you pull your tube out, she said no. I brushed her teeth and cleaned her up. I stayed with her for 2 ½ hours - she still was not in insolation - and she still had a germ that was very contagious - a week or so went by and my mom got the feeding tube back.

On March 30, 1998, at 10:15 a.m., Marlene called me and she did not know she was on speaker, I answered yes, this is Leslie - she said Hi this is Marlene at Palm Terrace, your mom choked on food and she is getting oxygen by the paramedics - don't worry she's okay. I asked did she die, Marlene said no. My associate at work, Annette, was standing by listening with me.

We asked how could she choke when she is on a feeding tube. There was no logical explanation. I asked Marlene what was my mom doing with food when she has a feeding tube - Marlene said, just calm down Leslie - I'm sorry. I raced to Palm Terrace. When I got to Palm Terrace, they told me your mom's okay, they just took her to Kaiser in Riverside. Once arriving to Kaiser in Riverside, the doctor told me my mom had died at Palm Terrace and he requested an investigation with the Coroner's office. Two to three hours later, the doctor came in and said, Dr. Sign called the coroners office and dropped the autopsy. I asked why and the doctor said he didn't know and advised me to contact the Coroners office in Riverside.

While waiting for my family - I started to investigate my mother's body. I noticed deep scratches along her chest - where the tube was, and her chest was really inflamed. Her right thumb nail was ripped off - completely off and her right eye was gray. Apparently, she went blind in that eye. The feeding tube was up in the chest (towards the rib cage) the last time my family and I saw the tube it was in a different place much closer to the stomach.

On Mach 31st, my husband and I went to Palm Terrace. I asked to speak to the Administrator - Rhonda Codwell - I was told she was busy - and could not see anyone. I asked where her office was and found her anyway. Rhonda and I met and I told her who I was - I asked her how my mom died and how come she choked on food when she had a feeding tube - Rhonda could not answer me. Rhonda said to me, I am sorry about your mother - I asked her for my mom's records and asked her who changed her feeding tube - Rhoda said we did, our nursing staff and the helpers - "as you know, Leslie, your mom pulled the tube out." I told her when I came to see my mom, the feeding tube was completely gone. Rhonda said, you're right, but we put it back so what are you trying to get to. I replied, I thought she was supposed to be sent to a hospital to have that done. Rhonda said "no", we have a trained staff to handle any medical procedure. I then again asked for my mom's medical records - Rhonda said, its too late our office staff is leaving and you can come back in a few days, we will have them ready.

I said no, get them right now. I have all night and I will even help you copy them. Rhonda then had a staff person from her office come and bring the records. Rhonda looked through them and took three to four pages out. I asked for those pages, but she said they didn't pertain to my mom. Then I asked what is the name of the person who changed my mom's feeding tube - she said she didn't know - I asked who was there when my mom was dying. Rhonda said she was there and at 6:00 am., your mother was fine. She thanked us.

She said that, "about 7:15 am, I saw your mom and she looked fine. She said she was hungry and she wanted something to eat."

About 8:30 am., your mom looked happy, but she was cold and tired and she wanted to sleep. Then, Rhonda stopped - she said nothing - I asked where did my mom get the food - how could she choke on the food when she supposedly had a feeding tube. Why did you guys tell me, my mom was okay and was still alive? Rhonda asked why are you asking all of these questions - I said my family needs to hear the truth and I left.

On June 17, 1997, my mother was admitted to Extend Care Nursing Home. In the beginning, it seemed to be a nice place. My mother was welcomed.

However, starting "August 1997", I noticed my mother's personal items were missing I had purchased for her four bumper pads, 1 chest bib, 1 diaper net padding for the wheel chair, knee and elbow pads, a bed cart, 2 blankets, food bibs and cotton. Every item ended up missing. I questioned the staff, but they knew nothing. I requested that a dentist check my mother's teeth. At each and every visit we made, I always brushed and cleaned my mom's teeth - the dentist never came out to see her. Her teeth started looking bad during her stay at Extended Care.

In "September 1997", a nurse was in my mother's room reviewing her chart. My husband and I walked in and the nurse looked at me and left - she came in her room several times - then she said to me "do you remember me Leslie?" It seemed funny that she knew my name. I replied "no." The nurse told me, I am the nurse who took care of your mother while she was at Orangetree Convalescent. While, at that point, I forgot that I had caught this woman yelling at my mother while she was at Orangetree, (please see notes on Orangetree, Nursing Home #1)

Starting at the end of September, my mom began getting bruises on her legs, (the size of quarters). In October 1997, the bruises got bigger, up and down her legs and arms - I told the nurse in charge that I wanted to know where she got the bruises from - they told me from her bed. So I bought more bumper pads for the rails. I also made cushion hand restraints. The hand restraints were long enough to turn right or left while in bed - but not long enough to hit herself. They told me my mom was hitting herself, but we saw no evidence of this. I contacted the doctor, he told me the nurses were complaining that my mom was always yelling and screaming and she was getting out of bed and falling. I told her doctors "that was impossible. During my mother's stay at home with us she never did such a thing." I requested that my mom have different nurses. Towards the end of October to early November 1997, my mom developed bed sores. I requested a special mattress. I again asked that a dentist come to see my mom I never got a reply. In the middle of November, while I was visiting my mom, a nurse stopped me at the door. She said your mom fell and hit her head - but she is okay. We took her to RGH Riverside and had x-rays taken. I then went to see my mom - she had a long black bruise on her right side of her face.

The bruise was very black and extended from her temple, across her nose down to her lips and across her ear. She had a smashed lip on the left lower side - she had bruises on her back some 8 -10 inches in diameter. I called the ombudsmen to do an investigation. They told me that there was nothing to worry about - implied it was okay if my mother fell and again did nothing. In December 1997, both her eyes were so black and blue, it was just awful. I started getting phone calls at work from Extended Care. The nurse in charge told me that they no longer wanted to care for my mom and said to pick her up or they were going to do a 5150 on her. (5150 is restraints - injections to slow down the person more or less, tie up the person in a straight jacket which they did do and carry them off to mental health to be evaluated). I then called my mother's doctor and told him what the nurses told me. He said the nurses were not authorized to do such a thing and he was going to take care of it. Later that day another nurse called me at home and stated that I better get my mom or else. I said or else what. She replied I am going to do a 5150. I told her that I spoke to the doctor and he told me that she could not do that. I asked why were they doing this - the nurse told me my mother was "lashing out" at them - jumping out of bed and falling, going outside and running from them. They said she tried to hide from them. She then said that the nurses all agreed to NOT CARE FOR HER any longer. After that, my mom's doctor called me and said I had less than two weeks to place her elsewhere. He also said my mom was not stable and she needed mental health - and that she probably did not have Huntington's. He said it was more a mental disorder and he then gave her more medication than she needed.

When I went to Extended Care, my mom was like a zombie. She could not talk, blink or move - she had bruises everywhere. They told me at the facility, that it was my mom's fault even though her bumper pads were again missing. They told me that they had sent her to ER to check to see if any concussions to her head had occurred. The following day, my brother Rico and his wife Valerie met me at the facility. I called the paramedics - my mom's eyes were so blackened. Anyhow, when the paramedics came out, I told them my thoughts and the lady who was the ambulance driver started to question the head nurse. She asked why wasn't this women brought into the emergency room earlier. They said she was there but when I asked for my mom's medical records to prove this, they

would not give them to me. We then took my mom to Preview Hospital in Riverside and had her evaluated. My mom was dehydrated and then they gave her a CATSCAN - Preview released her back to Extended Care.

I called the social workers at Preview Hospital - they told me that since my mom was a resident of Extended Care she had to go back until Extended Care released her to another home. Meanwhile, I called the administrator at Extended Care asking him questions like:

1. Where did my mom get those black eyes. Reply: I don't know.

2. My mom's eyes were so swollen she has blood dripping from the corners. Reply: She must of fell from the bed.

3. How did my mom fall from the bed when she has bed rails? Reply: She must have jumped over them.

4. How could she jump? She has no balance. Reply: I don't know.

5. My mom has very large bruises on the inside of her upper legs - close to her vagina, what happened? Reply: While jumping over the rails, she must of got stuck horse style.

6. My mom's eyelids are so swollen and thick filled with blood, how could she have fallen so hard to hit both eyes? Reply: She had to hit the corner of a table.

7. Where did my mom's special equipment go, the bed pads, bibs, diapers, etc? Reply: I'll check with the staff.

8. If my mom really fell from the bed, why didn't you make a medical report? Why was she not sent to ER each time? Reply: We did call you, but you were not home!

9. Well that is funny, I have voicemail at home and on my pager. There were no messages at all. Who left or called, let's ask them? Reply: well, I have to check into that.

10. How can one single person fall from bed so many time? How could she even hide from your staff? Nothing was in full detail or even explained to me what really was going on. Reply: Mrs. Oliva, I think I was nice enough to answer your questions. I need to leave now, goodbye.

My mom went back to Extend Care — this was just before Christmas — the same day, she got there, a nurse called me and left a message with my daughter. The nurse told (Marie) my daughter, tell your mom she has 12 hours to take her mom out or we will do a 5150 on her. My daughter got upset and paged me. I contacted Extended Care and the nurse told me your mom fell real hard. I told her to have my mom's doctor call me. I then called the ombudsmen and the State Licensing.

On Christmas Eve we took her gifts and food to eat. She was just sitting there looking helpless. I told my mom to get up, but there was no reply. I just so happened to have my camcorder running. My husband was recording, my mom's bruises looked like they were gone, but my mom would not sit up - she acted lifeless.

We got to Extended Care at 6:20 p.m. I kept on encouraging her to get up . We even took my mom for a drive to see the Christmas lights. We took her to eat and went to a Church. We then took her back to the nursing home. We left at 3:45 a.m. Christmas day. I came back with our grandchildren and some pictures. My mom looked like a zombie. I asked what they gave her, and the nurse said medication. I knew it must have been real strong because my mom could not move, she just stared straight ahead without blinking for one hour. I called her doctor and he said it was normal. I kept questioning the nurses, but got no reply. Just after Christmas about December 28th/29th, I dropped in to see my mom. She could not see through her eyes. There was blood dripping from her right corner eye. There was big bruise across her forehead, a large bruise on top of her head, on her chin and lip were bruised and the inside of her lip was all cut up.

Both her lower and bottom teeth were loose. Her shoulders were bruised from front to back. Her hips in front and back and inside thighs close to her vagina were very blackened, knees, feet and legs were bruised, and her toenails were torn down, tip of toes were cut up real badly - it just goes on - her eyelids were so swollen that they stuck out 1 ½ inches. All they said was to have her moved. Anyone could see that these injuries could not have come from a fall or have been caused by my mom herself. The nurse told me again she was going to do a 5150. I left and called several lawyers. I called the State Nursing. Once I left Extended Care, the nurses called my home saying "get your grandmother out of here or else she will keep falling."

Dr. Summerwin at Extended Care also left me a voicemail. He said your mother needs to be evaluated. She is severely depressed, she needs to go to mental health to be treated.

Meanwhile, I contacted a mental office in Riverside. I spoke to a social worker there before I could say anything, she said "Leslie, why is Dr. Summerwin sending your mother here." I told her I don't want her admitted because she has Huntington's, not mental disorders. The social worker said, your right, your mother does not belong here or a nursing home. The second social worker said the doctor faxed over my conservatorship papers without my knowledge. I told the social worker not to do anything, just hold off. I am going back to Extended Care. Also, I am calling a lawyer - when I got to Extended Care, they took out my mom's bed. She was on the floor on a mattress.

I picked my mom up and put her in a wheel chair. The administrator had one of his nurses go with me and my husband to mental health. We met with Lynn Slaughter (909) 358-4647 and Dr. Drew did an evaluation and sent my mom to RGH - Riverside County Hospital. Dr. Drew also requested that State Licensing Nurses investigate Extended Care. My mom was hospitalized from January 5, 1998 to January 15, 1998. We have not been advised of the investigation.

I think Congress and the President need to work on safer nursing homes for our parents. We, the people for the State of California, are not safe as we get older. Our lives depend on care givers, doctors and nursing facilities. Our lives and the lives of our parents are precious. I am asking you,

Congress and the President to stop and see the ugly abuse that our parents are getting. Those nursing facilities are stealing our hard working money and not providing the right care giving to our families. I think our parents should have the same equal rights. Our parents should be treated the same as we treat child abuse.

Sincerely,
Leslie Oliva

The CHAIRMAN. Obviously, your testimony, not only is very valuable to our consideration of this issue, but very moving as well. We are thankful you would come, but sorry to ask you to go through this experience again as you describe it to us. Thank you for doing that.

We would like to ask questions now of each of you. I will start. I am going to start with you, Ms. Curzon. When you noticed your husband's deteriorating health, you indicated that you called his doctor twice and went to his office twice to alert him to your husband's conditions. What, if any, response did you get from the doctor? And did you see your husband before your husband was transferred to the hospital?

Ms. CURZON. I will start with the last first. I did not see him, and when he had arrived at the hospital, none of the nursing home people told the hospital people that he had any relatives. So, finally, I found out lots of hours later, the next day, I could go up and see him.

The doctor's office had a liaison person that supposedly took care of the nursing home business, complaints, whatever. This person talked to me, but not the doctor, and after that they started giving him pureed food.

The CHAIRMAN. Did you discuss your concerns about your husband's condition with the nursing staff, and were they responsive to your concerns about his condition?

Ms. CURZON. They knew that I was very unhappy. I discussed it with the head nurse. I discussed it with the administrator of this nursing home. But somehow nothing seemed to ever change. I also had to take water to him. They never—he could not see well enough, so he should have been served water, but he was not.

The CHAIRMAN. Well, you, obviously, did what most people should do for relatives and friends who are in a nursing home. Obviously, you were there concerned about him, and showing that concern, and being observant, and that is something more relatives and friends should do, I think, as a result of what we are hearing today.

Did you ever have an occasion on your many visits to observe or to feed your husband?

Ms. CURZON. Yes, I did.

The CHAIRMAN. Was he hungry and thirsty?

Ms. CURZON. He was hungry. This was before his mouth got so sore. Due to his losing weight, his mouth shrunk, his teeth did not fit, and so his mouth developed these canker sores. Therefore, he could not eat. Then that also led to the pureed food. But I was there to—I stayed through noon hour every day, so that I could help him have food.

The CHAIRMAN. Did he want to eat?

Ms. CURZON. Oh, in the beginning, he was very hungry. When he went there, he had a good appetite, but due to the lack of hydration, and his mouth being so sore, he lost his appetite.

The CHAIRMAN. What were his eating habits like during the time that you cared for him at home, and it is my understanding you took care of him for several years at home before he went to the hospital.

Ms. CURZON. Yes, I did, and he had a marvelous appetite. Actually, food was the only pleasure one has at this stage, and he really enjoyed his food.

The CHAIRMAN. You mentioned your interaction with a state surveyor for the Board of Licensing, and she pointed out to you that the facility Survey and Inspection Reports were available for your review. After reviewing these records, you said that you identified a pattern of deficiencies. Can you explain more about what you found out from your review of the deficiency records and what showed up as a pattern to you.

Ms. CURZON. Well, the pattern was so evident in that they had been fined and cited, and then would rectify it, pay the fine, hire a few people, pass the inspection, and the people they did hire were, for the most part, untrained. They were probably paid minimum wage.

The CHAIRMAN. Looking back, do you wish that you would have known about the availability of these records earlier; in other words, do you think the deficiency records are really valuable to a family who is looking for a facility?

Ms. CURZON. Absolutely.

The CHAIRMAN. Do you happen to know if the facility received any deficiencies due to the quality of care delivered to your husband?

Ms. CURZON. I have not that knowledge, but the place closed due to the suit I brought.

The CHAIRMAN. Did you know that it is required for recent survey information to be readily available to the public and be available at the facility?

Ms. CURZON. I learned that after he was in this particular nursing home, that those records must be posted near the front door, so that all people can come and read them.

The CHAIRMAN. Ms. Oliva, I am struck by your description of your mother crying to you and begging you for help. You have said how shocked you were to find her hungry and thirsty when you visited her. How long had she been in the nursing home when you started finding her in the condition? Was it days, months, or weeks?

Ms. OLIVA. Within months.

The CHAIRMAN. Do you feel that the staff was properly trained in areas such as mealtime activities and cleaning pressure sores?

Ms. OLIVA. No.

The CHAIRMAN. Did you ever observe an aide helping your mother by turning her or repositioning her in a chair or bed as to prevent pressure sores?

Ms. OLIVA. I had always, on my visits with my mother, asked when was the last time she had been changed, turned, sat up, put in a wheelchair, and nobody could give me an actual answer. I would ask for help, and it would take just a nurse, a candy striper, up to 45 minutes, after me pacing up and down the hallways and asking for someone to come and help us.

The CHAIRMAN. When you contacted the ombudsman with your concerns about your mother's condition, how did the ombudsman handle your concerns, and could you give us something about your

conversation with him, what it was like, and did he or she come out to visit your mother?

Ms. OLIVA. When I contacted them, she sounded very, very concerned. But during the conversation, as it got more in-depth, as I explained to them, the heavy bruising that my mother was receiving, and that I felt that she was being severely abused. She was starving for water and food. They had told me that it was out of their hands, and they referred me to the State Licensing. An investigation had taken place at least, say, more than three times. I have never had anybody contact me back until a doctor at another facility—medical facility—started and did a request for an investigation.

The CHAIRMAN. Did the ombudsman come out to visit your mother?

Ms. OLIVA. They told me they had gone out, and there was no need for me to worry; that my mother had fallen, and it seemed to them that she was in fair condition. When I explained to them how can they point out her condition when she had so many bruising up and down the body, and loose teeth, she told me she could not answer that. She referred me then, again, to the State Licensing.

The CHAIRMAN. Senator Breaux.

Senator BREAUX. I would like to also join the chairman in saying thanks to each one of you for sharing this very difficult experience, not only with the Congress, but with all of the entire country.

I think, as terrible an experience that you have had, I think that you can know that by sharing that information with others, perhaps, others will not have to go through the same difficult time that both of you have experienced, and I think that we thank you very much for giving us this information.

I would also say, again, that the majority of nursing homes provide quality care. People can be assured that the people in those facilities are getting quality treatment and attention. But as long as there are a few that are not, then we have a problem, and that is why we are here today because the good nursing home facilities are indirectly hurt by the few that are bad.

I am impressed by two things that I think we are starting to find out; that, first, there is a need for adequate random inspections and, second, there must be a mechanism for making that information available to people when they select a nursing home. There is a Federal requirement that results of these inspections, I understand, be posted, but I dare say that it is difficult to find where they are posted, in most cases.

I am struck by the fact that we inspect machinery more than we inspect people. If you inspect a nursing home once a year, I wonder what it would be like if we inspected an airplane only once a year, or every several hours, like we do.

I am impressed by the fact that we can find more information by reading Consumer Reports on lawn mowers, and air conditioners, and sewing machines than we can find on facilities that treat people, and that has to change.

So I think that the chairman has covered the problems that you have experienced very adequately. It is now up to us to see what

additional laws need to be written and enforced to make sure it does not happen again.

I guess the only question I have to each one of you, when you found that there were problems, was there any place that you could go to, to say, "They are not treating my husband, they are not treating my mother properly. Do something"? Was there any place—is there not an ombudsman in California, the person that is supposed to be with the Department of Aging that is supposed to say, hey, come to me, and I will tell you how to fix this problem? Was there anybody?

Ms. CURZON. Not to my knowledge.

Ms. OLIVA. Uh-uh.

Senator BREAUX. How about you, Ms. Oliva? Is it Oliva?

Ms. OLIVA. Oliva.

Senator BREAUX. Was there any place? I mean, when you signed up to bring your mother there, did they give you anything that said, "Here is our certification. Here is how we have done over the past several years. If you have complaints, bring them here"? Did you get anything like that?

Ms. OLIVA. No.

Ms. CURZON. I understand there should be, but there was not in my case.

Senator BREAUX. You know we have that all available for so many things around here. Like I said, you can go pick up Consumer Reports and read all kinds of information on a bicycle, but you cannot get the same type of information on a nursing home.

I think that is the problem, and when something goes wrong, you have to have someplace where you can go.

Ms. CURZON. That is right.

Senator BREAUX. I do not think you had that here.

Ms. CURZON. Some Court of Appeals.

Senator BREAUX. You mentioned a litigation, which I take it you are involved in.

Ms. CURZON. Yes.

Senator BREAUX. Ms. Oliva, are you involved?

Ms. CURZON. The litigation in my suit is over, and it was settled out of court.

Senator BREAUX. Well, you see, we are talking about this Patient Bill of Rights, and we are talking about the question of giving people the right to sue, and that may be appropriate and proper, but generally it is after the fact.

Ms. CURZON. Yes.

Senator BREAUX. I mean, the patient is deceased.

Ms. CURZON. That is right.

Senator BREAUX. The treatment was denied, and we are saying, well, you can go to Federal court. Well, in 5 years you may have some resolution, which is far too late. There has got to be something that occurs more quickly to remedy the problem, not just to give you a settlement after it is over.

Ms. CURZON. Right. That is right.

Senator BREAUX. Because money can never replace people.

Ms. CURZON. Uh-uh.

Senator BREAUX. Well, I thank you very, very much. Your testimony has been very, very helpful, and we appreciate it.

Ms. CURZON. There was one point I would like to make, which I found out afterwards from people who had worked in nursing homes, and they told me that it is the policy to give better treatment to those who are able to pay rather than those who are under a Medicare/MediCal.

Senator BREAUX. That is a point, and I thank you for bringing it up because I had made a note to ask you. I wrote the same note. I will tell you, you ought to be in the Senate.

Is there a different care for patients who are not on Medicaid? And you think that, in your experience, there has been.

Ms. CURZON. That was my understanding from people who have worked in these and had administrative jobs, too. So that is a very sad thing.

Senator BREAUX. Yes, because that chart up there shows you where the money is coming from. Thirteen percent for nursing home care comes from Medicare, and 38 percent comes from the State Medicaid Program, which, unfortunately, is a statement about how we operate because we force people to spend all of their money, so they can become poor, so we can take care of them, which is ridiculous.

But, if you combine Medicare and Medicaid, and you have got 51 percent, a majority of the people in this country, are in nursing home care being paid for by a government program, by a combination of Federal and State. The quality of the care should not depend on who is paying the bill.

Thank you very much.

Ms. CURZON. You are welcome.

The CHAIRMAN. Senator Kohl.

Senator KOHL. Thank you, Mr. Chairman. Like all of us, I would like to thank you for coming here today and talking to us about your situations, the things that occurred to you and your families because it helps all of us and helps everybody across America, so you are to be commended, and we express our gratitude to you.

If you had to tell us one thing that we need to do to see to it that we do not have repetitions of what occurred to you, one thing that we need to do, what would you tell us that we need to do, Ms. Curzon and Ms. Oliva? Ms. Curzon.

Ms. CURZON. Perhaps there should be publicity regarding the status of every nursing home.

Senator KOHL. All right. But is it not true that, as we have heard today, many nursing homes that are providing inadequate care all year long pass inspections when they find out that the inspection day is coming? So they may be providing inadequate care and not being publicized; is that not true?

Ms. CURZON. That is true. After they are cited and fined, I do not know that it is ever made public outside of them posting it in their particular facility.

Senator KOHL. So when they are cited and fined, we need to publicize that more clearly?

Ms. CURZON. Yes.

Senator KOHL. So that people would not choose that facility.

Ms. CURZON. Absolutely.

Senator KOHL. Ms. Oliva.

Ms. OLIVA. I think that, to keep the eyes and ears more open, and to see and look into more of the investigations that are occurring in the homes, and once an investigation has been completed, to let the California nursing homes know that this will not ever happen again.

Senator KOHL. Are you both saying that State and Federal officials need to do a much better job of inspecting nursing homes adequately and frequently and then publicizing and fining those that are not performing adequately, so that we really do weed out those nonperformers?

Ms. OLIVA. Yes.

Ms. CURZON. Yes. And I do believe they are hiring untrained people to handle—actually, they call themselves skilled nursing homes, but if the people that work there are paid possibly a minimum wage and are working just a minimum amount of time, that is not good.

Senator KOHL. The hiring and training procedures, as well as the wage rate, needs to be addressed?

Ms. OLIVA. Yes.

Ms. CURZON. Yes.

Senator KOHL. Ms. Oliva.

Ms. OLIVA. I believe that. And what I have heard and seen in the nursing home, after speaking with one of the nurses there, she complained and other people had just kind of friendly spoke out that they were not paid enough, and it made me believe that the amount of pay that they were receiving is the amount of care that our parents are getting.

Senator KOHL. So you would agree that if local, State, and Federal officials did their jobs diligently and well, most of these problems would be much alleviated?

Ms. CURZON. Yes.

Ms. OLIVA. Yes.

Senator KOHL. Thank you. Thank you, Mr. Chairman.

The CHAIRMAN. Senator Kohl. Now Senator Burns.

Senator BURNS. Thank you, again, for coming today. I have a question for Ms. Oliva. What is a 5150?

Ms. OLIVA. 5150 is to be restrained they put them in a straightjacket form. They hold them to the ground, and then they inject them with some type of medication that slows down the body.

Senator BURNS. I did not know that, and I noticed that you had made it part of your testimony.

Ms. OLIVA. I was called several times at home, that if my mother was not removed from the home, that they were going to put her on a 5150, and I called doctors, hospitals during that time that I was being told that if she was not out of the facility, they were going to do that to her; basically, treat her like an animal and haul her out of the home.

Senator BURNS. I want to follow-up a little bit on a statement that my good friend from Louisiana pursued a while ago. It just seems like to me, as we debate the Patient's Bill of Rights and these new programs that will be debated in the next couple of weeks here in the Senate, there has to be some way of immediate internal and external review that one can appeal to at the time that you think there has been a malpractice or you are in a situa-

tion which you believe that is intolerable, and that review has to be done within a certain time of 48 hours or 24 hours or whichever because this is acute.

So I think there are some provisions that is being called for and that will be debated in this Congress that I think maybe should be taken into the area of nursing home regulations also, as we look at this. But it just sounds like to me that it is very hard to bring a lawsuit of maltreatment or abuse or negligence, but that is after the fact. We would like our loved ones to be taken care of. Next week it does not make a lot of difference. And so it would appear to me that we need some internal and external appeal mechanism that you can make your appeal to because you have a situation that needs attention right now and not tomorrow or the next day.

So thank you very much for your testimony this morning. I think it has been very worthwhile to us, and maybe working together with a lot of us, so that we can come up with some kind of an answer for you. We cannot take care of your situation. We are very sorry about that. But maybe it is not for naught that we learn things.

Thank you very much, Mr. Chairman.

Ms. CURZON. You are welcome.

Ms. OLIVA. You are welcome.

Senator BREAUX. Mr. Chairman.

The CHAIRMAN. Yes. Please go ahead.

Senator BREAUX. I just have one comment. We talked about having adequate information to make wise decisions about where you want to send someone who may need nursing home care, and sometimes it seems it is difficult to find that information.

I was looking at the Operations Manual, a very complicated document of a couple hundred pages, which is the document that people use when they inspect nursing homes, and my staff, actually—because they can read the fine print better than I can—noted one of the sections here, one of the regulations says that, ". . . when looking at a nursing home, that the inspector shall examine the results of the most recent survey of the facility that was conducted by Federal or State surveyors and any plan of correction in effect with respect to that facility, and that facility must make the results available for examination in a place readily accessible to residents and must post a notice of their availability."

I take it that, in both of your situations, you never were made aware of that document or ever saw that type of information posted anywhere that you could have read, or was it there, and you did not have the time to read it or—do you get my question?

Ms. CURZON. Some of the nursing homes I visited, preceding the one I chose because it had an available bed, had this document posted out by the front desk. But then after I learned about this place and I looked for it, I never found it.

Senator BREAUX. How about you, Ms. Oliva?

Ms. OLIVA. That is correct, same with me.

Senator BREAUX. You did not see it or you were not aware of it or did not notice it or it was not there, do you know?

Ms. OLIVA. I was not aware of it, and then there was one time where I had walked in, and it was posted up in the front for maybe a couple of hours. At that time, I did notice there was a State nurs-

ing head coming out, and when she had left, an hour after, it was not posted any more.

Senator BREAUX. They took it down after someone had inspected the facility?

Ms. OLIVA. Yes.

Senator BREAUX. One of the recommendations, I guess, more than a recommendation, I guess this is being put into effect by the Administration, says, "They will post individual nursing home survey results and violation records on the Internet to increase accountability and to flag repeat offenders, as well superior performers, for both families and the public."

I take it that you think that would be helpful. Ms. Curzon, I do not know if you are on the Internet. I am just trying to get on it now.

Ms. CURZON. Actually, the Internet was not available. But I think now it is in all phases. Why not? Why not publicize it?

Senator BREAUX. You can do a little comparison shopping.

Ms. CURZON. Right. Exactly.

Senator BREAUX. I think this is a very good idea. Thank you, again, for your statements.

Mr. Chairman, thank you.

The CHAIRMAN. Thank you very much for your testimony. As difficult as it is for you to repeat it to us, we appreciate very much because it is very important that we get this information out and that we respond accordingly. So I am going to thank you for coming, and we will call the next panel now. Thank you.

Ms. CURZON. You are welcome.

Ms. OLIVA. You are welcome.

The CHAIRMAN. Our second panel consists of insiders within the California nursing home industry. They will give us their insight as to what really goes on inside these nursing homes.

We have with us a former certified nursing aide, a former licensed vocational nurse. We have a medical director of a California nursing home, and a current nurse evaluator for California Survey and Certification System.

Initially, one of these three witnesses wanted to have her identity protected and to testify before the committee anonymously. She now has decided to stand alongside other witnesses and testify openly before us. The true name of the witness whom we had previously referred to as Clara B is actually, in real life, Patricia Lloyd.

So I would call Kathleen Duncan to the table. She moved to California in 1993. She worked in a nursing home for about a year as a certified nursing aide, CNA, as they are referred to. Following the appropriate training, she became an activities assistant and was later promoted to activities director. Ms. Duncan later went on to work as a patient advocate and in the admissions office.

She is here to tell us about some of the disturbing things she witnessed while working at a nursing home.

Our second witness, Patricia Lloyd, and I would ask her to come, worked for 5 years as a licensed vocational nurse in a California nursing home. Although she is not proud of some of the things she has seen and done, she felt that someone needed to step forward

and tell the truth. She is no longer employed with that nursing home or anywhere else in the nursing home industry.

Dr. Kathryn Locatell comes to us from Sacramento, CA, and would you come, please. She is board certified and licensed in the State of California and specializes in geriatric medicine. Dr. Locatell is also a professor at the University of California, Davis, School of Medicine. Beginning in March 1997 and continuing until this day, Dr. Locatell has served as a medical director of a nursing home. She is here today to tell us about her experiences in her capacity as director of nursing home.

We will go in the same order that I introduced you, and I thank each of you for your participation We will do each of your testimony, and then after all three of you have testified we will ask questions.

STATEMENT OF KATHLEEN DUNCAN, CERTIFIED NURSING ASSISTANT, ACTIVITIES DIRECTOR, SOCIAL SERVICES DESIGNEE, ADMISSIONS DIRECTOR

Ms. DUNCAN. Thank you, Senator Grassley, and all of you. It is nice to be invited, and it is nice to finally be heard.

I have worked in a variety of different areas in the skilled nursing facility, and I do not work there any more, and the reason why I do not work in skilled nursing any more is because of all of the problems. People that care get burnt out, and I cared too much, and I left, and I wanted to show you and tell you why I left and let you understand how deep some of these problems are, and I really hope that you do correct them because someday I would like to go back to the skilled nursing facility and be able to work and hold my head proud and say, "That is where I work."

I started working with seniors in Pennsylvania as a home health care aide, and we were given the luxury, I realize now, as a home health care aide of spending 2 to 3 hours with the patient, one patient doing their activities of daily living.

When I came to California, I had to do—I wanted to continue working with seniors, and so I went to a building that said I could learn how to—become certified, and also work. The first day I was there—I signed up for the course—that Sunday I was on the floor working.

I had been trained in Pennsylvania. There were others with me that were allowed on the floor that had not had any training. My first day at work I had—the first day I showed up on Sunday morning, I had 11 patients assigned to me. I had eight that were given showers, six that had to be fed, for various swallowing difficulties, and I worked really hard. I worked all day that day. I did not take breaks. I did not take a lunch. I did get the care done, barely. There are not enough hours in the day to do the level of care that people deserve when you have an assignment sheet that says you have 11 patients to care for.

That first day, as I was going around giving showers, I was the only one in the shower room, and I thought this was very weird because either I have been assigned all of the patients that need showers that day or other people just were not doing them. And in the middle of my frustration and flat running that day, I asked another CNA, "How do you get this done? How do you manage all of

this?" and he says, "Hey, you will get it. You will get it." That day was only——

The CHAIRMAN. Meaning that you will not do it, is that what they are basically——

Ms. DUNCAN. Eventually, that is what I learned. I learned that from him because I sat with him later that day when we were charting, and I watched him chart that he had showered his residents that he had been assigned to shower, and I was the only one in there. I will tell you right now he did not shower them, but he charted that he did.

I took that to my instructor the next day, and I said, "You know, this was not done. Why was this not done?"

She said, "Well, you know, maybe it was just an odd day. Maybe it was just a bad day."

I worked a lot of different shifts and a lot of different areas in that hospital, and that was not unusual. That was much more the norm than the unusual. I understood when he said it, when he was charting, yeah, I get it now. You do not necessarily do the work. You just chart that you do. That is how it goes.

I could not take that pace. I am sorry. I could not take the pace. I could not, and I decided that I wanted to still work with seniors, so I started working—I went to American River College—and I started working as an activities director. I really liked that. I mean, that really brings quality to their life, bringing them recreation, and pleasure.

I became part of what was called the Care Plan Team. When I worked with the Care Plan Team, I worked with a DON, I worked with therapy, and we would develop our assessments. They would go on the MDS, which is the Minimum Data Sheet, and I would assess the way that I was trained to assess, and sometimes this was in conflict with what the DON had in hers, and I was asked, on more than one occasion, to change my section of the MDS to better reflect what she had written down.

I did not do this willingly every time, but it was a very, very strong suggestion, and sometimes I would barter with my nurse. I would say, you know, "All right. I will change it the way you want me to change it if you will please send someone in to do a speech eval or a psych eval."

They would say, "OK, if I do that, will you sign this?"

"OK. Fine."

So, ultimately, in my mind, at least, I was able to give them the care, even if I had to change my assessment, and I often had to change the section on isolation. Isolation is really important to me for seniors because if you isolate a senior in a room, and you do not bring them into activities, activities stimulates their mind, it stimulates their senses, if they are in a room, their only communication outside is with a call light, and the call lights in the building I was in, in all of the five buildings that I have worked in, in California, the system did not work. The call light had to be where they can reach it, and sometimes it was not. Often it was not. They had to be able to push the button.

Arthritic patients could not hold the call light. They were just more prone to being abandoned in the room and left there, left there unattended. From there I was in a building to where, when

I would make complaints or I talked with the DON, I could not do that any more, and I wanted to help seniors, so I asked for a transfer to another building as the social service person.

One of my first assignments as that social service person was to go and check the personal belongings and the personal care that was given to the residents. I started with the belongings, and everybody brings something with them. They try to, and families bring things in. It is supposed to be documented in their medical records what was brought in. Personal belongings are important to everyone. They are important to you. You want to have them with you. And they would turn up missing, and they were gone.

Sometimes I would have families that said, "You know, I brought my mother and father's wedding picture in. Where is it?" It may not have even been documented in their medical records that it was brought in, and it is gone. A piece of their personal life is gone.

When I was looking for personal things, I was looking for toothbrushes, hair brushes, their dentures, their eyeglasses, things that they need every single day, and I could not find them. So I would ask the CNA, "Excuse me. Where is this person's dentures?" More than once they would go, "Huh? What? What dentures?" They did not even know that their patient had dentures.

I said, "Well, it says here you charted that you did your dental work, that you provided dental care. How did you provide dental care if you do not know where their dentures are?"

After that incident of looking at it, I looked and pulled up the activities of daily living sheet, which is how CNAs chart. They have to write down important things like how often they changed and how often they repositioned, how much a resident is fed is also charted by CNAs.

When I looked at this particular chart, there was one section that was really bothering me. There was a patient that had died 3 days previously, and CNAs had charted on all three shifts that they had fed this dead patient, they had showered this dead patient, they had changed this dead patient and, glory be, he ate 100 percent of all of his food. He was dead. They are so unobservant in their charting that they charted on someone that had not even been in the building for 3 days.

I went from there into admissions. As the admissions director, I talked with the discharge planners, and I worked at admitting people. It was my corporation's guidelines that I saw at admissions that were quality admissions, and they defined quality as having MediCal/Medicare, basically, Medicare A and B in place or another insurance because that meant that it was a higher billing rate that we could use.

I understand that there is a search out there for all levels of nursing care. But as a person in charge of admissions, I could easily just admit the people that paid well, and I did.

But they required a higher level of care, and when I started expressing to the nurse, the new DON, and I talked to the administrator that this higher level of care was not being met by our CNAs on the floor, he changed policy, and he changed my job, and he, respectfully, asked me—he put me in a back closet somewhere. He asked me to just—I was allowed to stay in the building. I was allowed to be paid at that pay level that I had worked up to, but I

basically was working as an activities assistant, just hanging around.

They did not want to hear from me any more, and I was OK with that for a while. I mean, it was OK. At least I got to stay by my patients because you do get attached to them. Those of us that care a lot get attached to the people and, up until the point where the activities director came to me and said, "I have to fire one of my staff because I have to keep you." I did not want to be the reason why someone got fired, so I quit.

The CHAIRMAN. What was the reason for his having to keep you? He wanted you around where he could keep his eye on you?

Ms. DUNCAN. Yes. Well, no, he actually did not. He did not want me around admissions any more, and he—I do not think you can fire somebody and change their job description and fire them. I do not particularly think that is kind of legal. So when he decided to change the job description, and he changed it to where—I am not a registered nurse—and he changed it to where it was required that my position be a registered nurse, then I could no longer hold that position. So he could not, I guess in good conscience or legally, fire me because he changed his mind on that position. It is not required by the state that your admission person be an RN, at least it was not at that time. So then he just put me off.

I cannot tell you the stress of working in a skilled nursing facility. There is stress because you care, and then you have stress that comes from a higher level, a corporate level, to where they want you, I guess, to live with their policies, live within their policies. I found that those CNAs often get the—they get the burden of the work. They also get a lot of the burden that I do not think is fairly theirs. You cannot expect a human being to be able to do 11 patients or give—there is not enough time. But if they did not say that they did, then the company would probably fire them. So they did what they had to do to keep their job.

I also, you know, when you talk about surveys and you ask that the surveys come and you think that they are supposed to be a surprise, they are not. No. You guys go on a relatively predictable schedule. If you come into the area and you go to one nursing home, you generally kind of follow around—you could draw a circle on the map of where they are going, and our administrators knew. Our administrators knew to the point that they definitely would add extra staff. I have been pulled on two occasions from my building that was owned by one person of this corporation to a whole other city. I was pulled out of Petaluma, in California, to spend 4 days in Stockton as an extra body on their activities staff, and then I went back to my old job. I did this twice, and it is not an uncommon practice.

The CHAIRMAN. Just to be around when the inspector came around?

Ms. DUNCAN. Right. So it looks like you have a really good staff of people adequately meeting their needs. That is the part that really bothered me about survey is that we knew it was coming, they added extra staff. The staff that was there was terrified into doing the absolute best they could. But when the survey left, it was back to usual.

Just to illustrate this, in my statement, I told you about a building, like she said, that the survey pages were there and then they were not. I had a survey team coming in to a building, and I was in activities, and I watched the corporation go to the other buildings, pull the decorations off the walls in the other building, put them up in the lobby of the building where a survey was coming to, and as soon as survey left, hey, they returned all the decorations back.

It is very easy to make something look nice for a few days, to make charts look nice. I have watched, on more than one occasion, prior to survey, teams that would come in sponsored by the corporation to review the medical records. The medical records they found that were not up to snuff, they ripped the page out, and they rewrote it. I sat there and watched with a table of people with different colored pens just recreate charts, and I know this is wrong. They should have charted it right in the first place, and charting is very important. CNA charting is massively important because the CNA spends the most time with the patient. If you give them the time, and they chart it properly, you can predict problems before they are problems.

I have tried to summarize. My statement was kind of long and rather wordy.

The CHAIRMAN. I want to make it clear your entire statement, if you want us to, and we want to, will be printed in the record.

Ms. DUNCAN. Yes, please, because I am afraid there was so much to say and so many problems, and I just sort of got carried away, and it is kind of long, and I want everybody to read it because I want everybody to understand that it is so important. It is so important that when you tell me one-third or whatever have been—I am saying, well, that means the other two-thirds hide it very well because I do not think that it is—I think it is more rampant than you believe because it is very easy to hide from survey everything because you are only there for a little bit, and it is all facial, it is all talk. I can write down, and I could write you a letter right now that says I was the President. It does not mean it is true. CNAs write down that they have given showers. That does not mean it is true.

[The prepared statement of Ms. Duncan follows:]

TESTIMONY OF KATHLEEN DUNCAN
CERTIFIED NURSING ASSISTANT, ACTIVITIES DIRECTOR,
SOCIAL SERVICES DESIGNEE, ADMISSION DIRECTOR

SUBJECT:TESTIMONY FOR OVERSIGHT HEARING

DATE:07/27/98

Senator Grassley, members of the Special Committee on Aging:

I would like to thank you for inviting me to testify. This allows me the opportunity to be heard. I felt when I was working in Skilled Nursing Facilities (SNFs) as if few heard my complaints and even fewer cared. I hope that what I have to share with you gives you a better understanding of the daily occurrences in SNFs that led to me quitting the field. I could not make a difference, as one small voice. It is my greatest wish that this hearing may lead to changes that really make a difference in the quality of life and care given to California seniors in SNFs.

I quit working in SNFs but continued to work with seniors in California. My next employment in the senior field was at a municipal level and I found the work very rewarding. I have kept busy in many volunteer organizations. I was the District Coordinator for the AARP's Tax Aide program for the 1997 tax year. I am the Area Agency on Aging advisory board representative for Vacaville. I also sit on the board of directors for the Vacaville Social Service Corporation as a representative on senior issues. I am the mother of four children and was the caretaker/Durable Power of Attorney for my father. He passed away in a local nursing home in March of last year at 78 years old.

I have much I would like to share with you.

I began working with seniors in Pennsylvania as a home health care aide. I helped two to three seniors a day with their basic activities of daily living. I spent approximately 2 hours with each client. I enjoyed the work.

When I moved to California, my home state, I wanted to continue this work. I was not certified to work in California, my home state, I wanted to continue this work. I was not certified to work in California so I responded to an ad that stated I could become certified and be paid. I began my classes and was allowed to work almost immediately on the floor. My first assignment was to work the morning shift on Sunday in the Alzheimer wing of the SNF. I arrived and received my assigned residents. I was astonished to see 11 residents on my list, 8 with showers due that shift. It was the policy of that SNF to give the residents breakfast in their beds on Sunday. This sounds rather nice, but 6 of my assigned residents needed to be fed. Proper feeding techniques include insuring that the residents are eating the texture of meal that he or she can swallow. (I.e.; mechanical soft, slight pureed, pureed or almost a liquid state. Also liquids are difficult for some to swallow and may require thickening to prevent aspirating fluids into the lungs) It also means noting that the resident has completely swallowed what was fed before offering another bit. My training in Pennsylvania included feeding of clients with swallowing problems. I had not yet received training yet in classes in California. I was expected to feed residents that shift. Residents with swallowing problems need

special care when being fed to insure that they swallow completely or they can aspirate food into their lungs. This special care takes extra time, time that morning that I did not know where I was going to find. I brought the food to the residents by room. Feeding everyone in the room, self-feeders and the feeders. This is how it should be done. How would you feel to be unable to feed yourself? Then you must sit looking at your food or watching your roommate eat? The correct way to pass food means that I had to go back to the kitchen and have trays warmed as I went to each room. In addition, CNAs must chart the percentage of food and liquid consumed. It is important to note changes in eating patterns. It is important to accurately administer and record fluids to prevent dehydration.

I now was faced with the daunting task of showering 8 residents. Alzheimer residents, in my experience, are more difficult to shower. I asked another CNA how was I expected to get this all done - his response "you'll get it." I spent most of the shift showering my residents. I answered call lights and nursing requests for assistance in between giving showers. As I worked, I noticed that either I had all the residents that needed showers or the other CNAs were just not doing them. There was only one large shower room on that wing.

There are other duties for me to accomplish in my shift. The residents in wheelchairs needed to be repositioned in their chairs to prevent decubitus ulcers/skin breakdown. I saw many residents with various stages of bedsores on them. I was taught in my classes that bedsores were preventable by: Cushioning boney prominences, Changing incontinent residents to keep them dry, Keeping residents hydrated and Repositioning them a minimum of every 2 hours. Most of the residents were in restraints. Restraints can prevent falling but also do not allow for self-repositioning in some cases. If a CNA was not aware a resident needed to go to the bathroom when restrained, it could cause the resident to wet him or herself. I feel this causes a loss of dignity and can become a habit with the resident, thus leading to the resident becoming incontinent. It is important for a CNA to take special care in repositioning residents or the delicate skin can bruise. The residents I cared for were incontinent and had to be kept dry to prevent decubitus ulcers/skin breakdown. I would also like to say that it is a matter of dignity to be kept clean and dry. The residents I cared for in my experiences often either denied they were wet or soiled or did not realize it because of cognitive impairments. I would have to check; asking was not always effective. It is also an important part of charting at the end of the shift. If a CNA notices that the resident is not urinating, it could mean they have an infection or a more serious condition. Bowel movements need to be accurately charted to note any possible bowel obstructions or constipation BEFORE it becomes a problem. I have heard many CNAs state "Hey, I asked and they said they were fine." I worked through my breaks and lunch that day and many of the days that followed.

The end of shift is the time to chart the care that was given. I HONESTLY charted what care I had given. I did notice that others near me charted that they showered their assigned residents and changed them. I knew that this was untrue. I reported this to my instructor, her response "Maybe you were mistaken or it may have been an unusual day." I worked other shifts and other wings of that hospital and it appeared to me that this lack of quality was the norm NOT the unusual.

I now understood what the CNA meant when he said I would "get it." He meant you do not necessarily do the care JUST chart that you do. I reported this to the hospital administrator. She said

that she would investigate. I told her that when I searched for assistance I found many of the CNAs on the patio smoking and visiting. I also saw them in the break room during times when there were not breaks. At this time, I would also like to say that I feel the charting/evaluations done by the CNA is key to quality care. The CNA has the most personal contact with the resident. Proper care and assessment of the residents can be critical to preventing problems like skin breakdowns, dehydration, falls, and other conditions. The charting forms use/d by the CNAs are often a mere check list, where one CNA will copy whatever check mark was left by the previous CNA. I reported this charting failure by other CNAs. One week later, as these matters continued, I asked for a transfer to another building.

I began work at another building but many of the same problems seemed to be there also. I completed my certification training and passed the board. I began a new position the day I graduated - I started as an Activity Assistant. I enjoyed this position. I felt I was able to add much to the meaning and quality of life of the residents through recreation. I enrolled at American River College for the certification program for Activity Coordinator/Director. As an Activity Director, I was part of the care plan team. I was responsible for assessing the activity needs of each resident and record this assessment in the Minimum Data Set (MDS) in the section for Activities. I developed activities to meet these needs. I also charted progress notes. I worked with the care plan team - with Nursing, Social Services and sometimes therapy. In my section of the MDS, I was to assess the amount of time spent in activities and in self-recreation. It was important to note anyone who might be an isolation case. This would require more in-room visits and other social charting by Social Services and in soem cases the nursing staff. There were times when I was asked STRONGLY to change my assessment because it was counter or not consistent with the others. I felt that by my criteria on the MDS I was correct in my assessments. Isolation is a problem that reflects into all aspects of the resident's life. They can mentally disassociate from others/withdraw. An alert and oriented resident is aware of their environment. An alert resident can demand care and report shortcomings. If they stay in their room, the care they receive is completely reliant on the call light system.

The call light system, in many of the hospitals I worked in, was insufficient at best. The call light must be in reach of the resident. The call light has to be answered in a timely manner. The resident must be cognitively alert enough to recognize the need to use the call light. A resident that is up and participating in activities has stimulants to all of their senses and a staff person with them in the room to help recognize their needs. It is more trouble for CNAs to get the resident up, properly cleaned and dressed than to wash them up a little and leave them in their bed. The nurse may have to move a resident to their room for treatments if they are in activities so it is easier for them if they leave the resident in their room. HOWEVER, they did not wish to TRIGGER the MDS as a possible isolation case because this would result in more charting and other triggers in the MDS. On more than one occasion, the Director of Nursing would change my section of the MDS to better match her assessment. In other words, she would promise to have her nurses take special care or order evaluations done for the resident if I would "go along with this." I felt that it was in my best interest to agree and sometime I got the care I thought the resident needed. I left that building taking a position as a social service designee.

THE SURVEY MADNESS

Documentation showing consistency is just one aspect of survey. There were many others. Survey is the main motivation of each building where I worked. I have been pulled from my to "help" another building where a survey was expected or they were in survey. Extra staff was always budgeted for those periods just before and during survey. I realize survey is supposed to be a "surprise" but it rarely is. The survey teams follow predictable patterns that the administrators of the various buildings were aware of. When the survey team arrived they witnessed more staff than was usual and a staff scared into providing the best care they could - care that should be the SAME quality all year round but was not.

I saw in two buildings medical record evaluation teams who would come before survey. They had personnel from other buildings and the nursing staff of the building that was expecting survey. This team would look over as many medical records as they could to find any problems. They would change the documents if needed. I witnessed nurses and others recreating medical records, sitting around a table with different pens back-dating records to "correct" them.

They survey teams arrival affected every area of the hospital. The housekeeping staff would be increased and any projects would be completed before the survey. Building projects — from new tiles for residents' bathrooms to new lobby furniture — would be completed. In one building I was in, just before survey, the lobby was redecorated by borrowing decorations from other buildings. These were returned after the survey. Making the facility a more homelike environment was a priority just before survey. Residents' rooms were decorated. New blankets and homey touches were added. All year I asked for money to decorate residents' rooms or the activity room, dining room, etc. and I would be told no but during survey, money was suddenly available. The monthly budget per resident for activities was less than $2. It was difficult to maintain equipment/supplies on this budget BUT if activities needed supplies during or before survey I was much more likely to get them, usually not out of the activity budget. Company was coming, clean the house.

Survey is vital to the quality of care received by residents but residents deserve quality care all year not just around and during survey time. I suggest that smaller teams arrive to survey buildings in the area simultaneously and at unpredictable times. Take a "secret shopper" type of pre-survey. The afternoon, weekend, and night shifts would be a good time to arrive. Try walking around when there are little or no managers in the building. Managers tried to correct problems but often they had to SEE them first. Covering up was a way of life in the buildings where I worked.

My administrator asked me to assess the records on the personal care giving to residents: showers, dental hygiene, personal belongings. I found that personal property w as missing or not documented. Residents' belongings were in other residents' rooms. Some residents had no clothing on their intake sheets. In some cases, this was an accurate reflection of the residents' belongings and at other times it was not. As a social service designee, I contacted families to clothe these residents or looked into their resident fund to see if I could buy some clothes for them. I also contacted the Ombudsmen on this and other occasions, never receiving a reply. I asked the CNAs where the personal hygiene objects of the resident were. Many had no idea. I asked "So how did you brush his teeth this morning then?" They charted that they had provided dental.

In checking the ADL charts (Activities of Daily Living), I found that CNAs had charted that they had fed and showered residents that had passed away days prior. I reported these findings to the administrator and the medical records department did an audit finding many more problems. I do not believe that this was ever reported to licensing but I know the ADL's were corrected. I hope this illustrates to you how charting can say anything you want it to and that many CNAs do not pay close enough attention to their charting to realize that they charted for two days, all three shifts, on a person who was dead.

SHOW ME THE MONEY

I was offered a position away from the floor as an Admission Director. I took the position because I needed a mental break from the floor of the facility. The break did not last long. Maintaining census in the facility with quality admissions was more than a full-time job. It was impressed upon me the importance of keeping census up. Staffing was maintained by census and many in the building wanted to work. The corporation wanted admissions that had good, established medical insurance. I was instructed to focus my attention on admitting residents with Medicare or other insurance that could be billed for the ancillary services. I worked within the corporation guidelines but I expressed concerns about the ability to meet the needs of these admits that had a higher acuity level.

I worked closely with the DON (Director of Nurses) but eventually there was a shift in administrators and a new DON was hired. The new administrator decided that they would change my position to require a RN (Registered Nurse). I was offered to be kept on staff at the same level but as an Activity Assistant. For awhile I accepted this until the Activity Director was instructed to cut someone else and schedule me in the time. I did not want to be the reason for someone being fired and resigned. I left the Skilled Nursing Facility area and have not returned.

There are many other incidents I could share with you. I hope that this overview of my career in SNFs has provided you with enough information for you to formulate questions. Thank you for your time. I also offer my personal assistance in any way that I can to help in your endeavor.

The CHAIRMAN. Thank you very much.
Ms. DUNCAN. You are welcome.
The CHAIRMAN. Ms. Lloyd.

STATEMENT OF PATRICIA LLOYD, LVN

Ms. LLOYD. Thank you. I am very nervous to be here, so you will have to bear with me. I am going to try to make eye contact with you, but bear with me.

Thank you, Senator Grassley. I am so glad you are doing this. Thank you for inviting me to discuss my concerns about the failure of the California nursing homes to deliver quality care to our elders.

In 1988, I was hired in my first California nursing home the day after I arrived from Texas. The nursing facility which hired me did not check my background or even determine if I was licensed in California. I began working there the next day, and this is while I was waiting for a local acute care hospital to complete their reference and background checks on me, as was their practice.

During my 4 months at this nursing home, I witnessed the rape of an elderly woman. I was asked to leave with 2 weeks' pay because I objected to the false manner in which the nursing home documented the rape. I followed the case and assisted in the conviction of a male CNA, who had a history of going from facility to facility.

In 1991, I took my second job in a private nursing home in Northern California. I rose quickly through the ranks from a charge nurse position to the director of staff development, which is the No. 2 position in the nursing department. I was employed in this particular facility for 4 years, serving under three administrators, and six directors of nursing and two owners.

Because I had previously worked in a skilled nursing facility within a California prison I was particularly upset about the quality of care in the private facilities, especially in regard to the staffing issues. For example, the patient-to-nursing staff ratio in a skilled nursing facility inside of our prisons is four-to-one, and this does not include the guards. Compare the staffing ratio to that of California's private skilled nursing facilities, and it is twenty-to-one.

I would really like to not follow my statement and just kind of ask you to do something for me. I would like you to sit on your hands. I would really like you to just take both of your hands and just sit on them, if everyone in here would do that, you will understand what all this means, what all of this is about.

You are talking about dependent people who are so dependent on us they cannot even wipe their nose, they cannot grab a glass of water. "I am thirsty," and they cannot reach that glass of water. They are dependent on us. Sit on your hands. See how it feels. Just sit here, sit here all day, and when you go home tonight put your arm underneath your body, and I want you to lay there and be miserable. It hurts, and they depend on us.

I am going to keep reading because that is the only way I am going to cover everything. The skilled facility where I worked for 4 years was home to 120 residents. It was frequently staffed on

night shift with one nurse and two certified nursing assistants for all 120 patients.

On the day shift, it was common for CNAs to be responsible for providing total care to 20 or more patients. The most unfortunate dilemma I faced working in the nursing home was knowing how severely the understaffing was affecting the care of the residents, and that temporary agency nursing personnel could and should be hired. The administration refused to even hear any requests for these outside services.

In my experience, neglect and abuse of residents and nursing homes is primarily a function of staffing. Nursing homes are understaffed with underqualified, underpaid, and undersupervised nursing personnel. As a result of this understaffing, patients are suffering, and even as we sit here today, they are dying from starvation, dehydration, sepsis from untreated bed sores, bowel impactions, and urinary tract infections.

Weight loss is an unfortunate, preventable, recurring event in California skilled facilities. It is primarily due to the understaffing of the skilled facilities. For example, I reviewed the records of an elderly female resident who lost more than one-third of her body weight in 3 months. Due, in large part, to her severe weight loss the 78-year-old woman developed Stage III bed sores, and these are bed sores that are deep muscle and bone involvement.

She had no terminal medical condition and was ambulatory with assistance when she came to this facility. This unfortunate woman died within 2 weeks of her admission to an acute care hospital from sepsis. I wish this was an isolated incident, but, Senator, committee members, this is every day in California, and it is rampant.

Records in the skilled nursing facility where I was employed were falsified on daily basis, and I need to emphasis daily basis. In fact, one could say it was policy and procedure to all of the administrators. For example, every month all of the records were taken into the director of nursing's office, blinds were drawn and the records were pored over. Any holes in the records would be filled in. In other words, a resident who had not received his medications, as prescribed, according to his record, would be filled in with initials of nursing staff who may or may not have even been on duty at the time.

The same was done with all documents regarding the residents' care, especially the federally mandated MDS and quarterly assessment. Problem patients that were potential for litigation or scrutiny by the Department of Health Services would receive very special attention. These patients' records were often rewritten and, at times, totally fabricated with the participation and ratification of our top administrators.

Falsifications of records in nursing homes occurs on a daily basis for a variety of reasons, the most common of which is understaffing. The facilities do not have enough staff to deliver the necessary care to the residents, and residents are not fed, hydrated, or repositioned adequately, and negative outcomes are the result.

Chemical and physical restraints are used in lieu of activities and exercise all for the convenience of the nursing facilities and, in many cases, for profit.

I am a strong believer in the MDS process. However, it is not carried out in the skilled nursing facilities, and it is not enforced by DHS. In fact, a DHS nurse evaluator who now works as a consultant for the nursing home industry testified in a deposition in which I had participated that the MDS was strictly paper compliance and, in her view, it was unnecessary. Therefore, she was testifying in favor of the nursing home, despite the fact that the MDS in this case did not reflect an accurate assessment or generate an appropriate plan of care for the resident in question.

The resident began developing a bed sore within 10 days of admission. The resident was a short-term respite-care resident who, rightfully, should have gone home in the same condition she arrived. Instead, the resident required three surgeries to remove infected bone and tissue, all because of the preventable bed sores she developed.

This elderly woman spent 3 months post-surgeries immobilized, laying on her stomach. I must emphasize that she had lived, on her own, as a paraplegic in her own home for more than 10 years without ever having a bed sore.

The surgeries cost us taxpayers in excess of $80,000. How ironic that she spent over $3,000 of her own money to develop this bed sore. To this day, this lovely lady will describe this nursing home as a dungeon.

It is my opinion that the MDS is the most informative and helpful tool available to the nursing facilities. It is a federally mandated assessment tool implemented by Congress in 1987. The reason for creating this critical assessment tool was valid when first enacted, and it is still valid today. It needs to be enforced.

There is no question that many of these questionable activities were carried out to ensure financial gain for these facilities. On the MDS assessment form, a certain code will indicate if a resident at an appropriate level of care. MediCal funding is limited to residents who have impairments in their cognition or physical functioning. I was trained and instructed, as an MDS coordinator, to code every federally and state-funded patient as having physical and cognitive impairments that did not reflect the patient's actual condition, but rather to ensure that the facility would get the payment.

I realized the significance of tampering with the paperwork only when a private pay patient who had run out of funds was denied funding by MediCal because her MDS was submitted with accurate information.

One very disturbing example, in my opinion what amounts to Medicare fraud, involved a nasogastric tube patient. She had 100 days of Medicare coverage because she had a nasogastric tube inserted for nutritional support. During a care conference with the family, they requested to withdraw the feeding because of the permanent, irreversible damage to their mother. In the patient's advance directive, her wishes were that her life not be sustained by artificial means, such as a feeding tube.

I went to the admissions coordinator and was told that this patient had 31 more days left of her Medicare, so we should wait until her Medicare funding had run out. The wishes of the patient

and her family were denied as a result of this calculated maneuver on the part of the nursing home administration.

I hope that you Senators and the audience today will not be quick to judge these employees of long-term care facilities. Like myself, they may believe that they are one of the few lights in the darkness, and they may have been manipulated into believing there are limited funds available to these residents.

In one extreme case, a plea came from the owner in a staff meeting to convince all of the staff that funding was so poor that this dedicated and caring owner had to take out a second mortgage on one of his two million-dollar-homes. He was lying and deceiving the staff, as was revealed during court testimony.

These same underpaid caregivers are, at times, your family's only access to a fresh bar of soap, shampoo, and love not provided by the facility. They use their own money to buy your mother's diapers, soap, and shampoo, and even clothing for these residents, when, in fact, the monthly gross income from Medicare and Medicaid billing alone were hundreds of thousands of dollars a month.

In conclusion of this difficult testimony, I would like to thank you, Senator Grassley, and members of the committee for heaving this heart-wrenching and, yet, terribly overdue investigation and hearing.

I would challenge each of you to remember our elderly and protect the rights of the forgotten, silent, and, perhaps, nonvoting contributors of our society. It is my belief that we would never tolerate these conditions in nurseries and day care centers for our children, and we must object to this horrific mistreatment of our grandparents and parents.

Thank you so much.

[The prepared statement of Ms. Lloyd follows:]

Testimony of Clara B., LVN
Before the Hearing of the
UNITED STATES SENATE SPECIAL COMMITTEE ON AGING
"Betrayal: The Quality of Care in California Nursing Homes"
July 27, 1998

Senator Grassley and Members of the Committee:

Thank you for inviting me to discuss my concerns about the failure of California nursing homes to deliver quality care to our elders.

In 1988, I was hired in my first California nursing home, the day after I arrived from Texas. The nursing facility which hired me did not check my background or even determine if I was licensed in California. I began work there while waiting for the local acute care hospital to complete their reference and background checks of me, as was their practice. During my four months at this nursing home, I witnessed the rape of an elderly woman. I was asked to leave with two weeks pay because I objected to the false manner in which the nursing home documented the rape. I followed the case and assisted in the conviction of a male CNA, who had a history of moving from facility to facility.

In 1991, I took my second job in a private nursing home in Northern California and rose through the ranks from a charge nurse to Director of Staff Development, the number 2 position in the nursing department. I was employed in this particular facility for four years, serving under three administrations, six directors of nursing, and two owners.

Staffing

Because I had previously worked in a skilled nursing facility within a California prison, I was particularly upset about the quality of care in this private facility, especially in regard to staffing issues. For example, the patient to nursing staff ratio in the skilled nursing facility inside the prison was 4 to 1. This ratio does not include the guards in the skilled nursing facility. Compare this staffing ratio to that found in California's private skilled nursing facilities–20 to 1.

The skilled facility where I worked for 4 years, was home to 120 residents. It was frequently staffed on night shift with 1 nurse and 2 Certified Nursing Assistants [CNA's] for all 120 patients. On the day shift it was common for the CNA's to be responsible for providing total care, including feeding, bathing, oral care, exercise, repositioning, activities, and social interaction, to 20 or more patients. If they saw a patient one time on their shift the patient was lucky! The most unfortunate dilemma I faced working in this nursing home was knowing how severely the understaffing was affecting the care for the residents, and that temporary agency nursing personnel could and should have been hired. The administration refused to even hear a request for these outside services. Regardless of patient acuity and missing staff, they refused to ensure that sufficient employees were available to care for the residents.

In my experience, neglect and abuse of residents in nursing homes is primarily a function of staffing. Nursing homes are understaffed with unqualified, underpaid and unsupervised nursing personnel. As a result of this understaffing, patients suffer malnutrition, dehydration, bedsores, urinary tract infections, fractures and loss of limbs from gangrenous bedsores. As we sit here today, there are nursing home patients dying from starvation, dehydration, and sepsis from untreated bedsores, bowel impactions and urinary tract infections.

Weight Loss

Weight loss is an unfortunate, preventable recurring event in California skilled nursing facility. It is primarily due to the understaffing of the skilled nursing facility which leads to residents not being fed or given water. For example, I reviewed the records of an elderly female resident who lost more than one third of her body weight in three months. Due in large part to her severe weight loss, this 78-year-old woman developed three Stage IV bedsores. She had no terminal medical condition, and was ambulatory with assistance upon her admission to the facility. This unfortunate woman died within two weeks of her admission to an acute care hospital from sepsis. I wish this were an isolated incident, but Senator Grassley and Members of the Committee, this is a daily occurrence in California nursing homes.

Falsification of Records

Records in the skilled nursing facility where I was employed were falsified on a daily basis. This was standard operating procedure within the facility. In fact one could say it was policy and procedure under all of three administrations. For example, every month all of the medication administration records would be taken into the Director of Nursing's office, the blinds drawn and the records would be pored over. Any holes in the records would be filled in. In other words, a resident who had not received his medications as prescribed, according to his record, we would fill in the blanks with initials of nursing staff, who may or may not have even been on duty at the time!

The same was done with treatment administration records, weekly nursing summaries, activities of daily living sheets, documents recording dietary intake and output, wound assessment and treatment records, restorative aid records, and last but not least the MDS [Minimum Data Set] and quarterly assessments. Problem patients that were potential for litigation or Department of Health Services scrutiny would receive special attention. These patients' records were often rewritten and totally fabricated with the participation and ratification of the Administration, including the Director of Nursing, Owner and Medical Director. Even when the Administration hired industry consultants to assist in pre-survey preparation, the consultants did not guide us in following state and federal regulations, instead they were more concerned with paper compliance. So every chart was reviewed and ***prepared*** for state survey.

Falsification of records in nursing homes occurs on a daily basis for a variety of reasons, the most common of which is understaffing. The facilities simply do not have

enough staff to deliver the necessary care to their residents. Residents are not fed, hydrated or repositioned adequately, and negative outcomes are the result. Chemical and physical restraints are used in lieu of activities and exercise, all for the convenience of the nursing facilities and in many cases for their profits.

The Minimum Data Set

I am a strong believer in the MDS process, however, it is not carried out in the skilled nursing facility, ***and is not enforced by DHS***. In fact, a DHS nurse evaluator who now works as a consultant for the nursing home industry testified in a deposition, in which I participated, that the MDS was "strictly paper compliance," and was in her view unnecessary. Therefore, she was testifying in favor of the nursing home, despite the fact that the MDS in that case did not reflect an accurate assessment or generate an appropriate plan of care for the resident in question. This resident began developing a bedsore within ten days of admission. This resident was a short term respite care resident, who rightfully should have gone home in the same condition that she arrived. Instead, this resident required three surgeries to remove infected bone and tissue and to replace the skin she lost to the bedsore with skin from another part of her body, all because of the preventable bedsore she developed in the skilled nursing facility where I worked. This elderly woman spent three months post-surgeries immobilized, laying on her stomach. I must emphasize that she had been living on her own as a paraplegic in her own home for more than ten years without any bedsores. These surgeries cost the taxpayers in excess of $80,000. How ironic that she spent in excess of $3,000 of her own money for a bedsore that cost this resident her independence for life. To this day she describes the nursing home as a ***dungeon***.

In my opinion the MDS is the most informative and helpful assessment tool available to the nursing facility. It is a federally mandated assessment tool, implemented by Congress in 1987. The reason for creating this critical assessment tool was valid when first enacted and it is valid today. It must be enforced!

There is no question that many of these questionable activities were carried out to ensure financial gain for the facility. For example, for residents who enter a long term care facility funded by MediCal, the criterion for the amount of MediCal funding is determined by several factors. Cognitive patterns, i.e., their ability to recall, short and long term memory and physical functioning, i.e., body control problems and ambulation, represent two areas most likely to trigger the highest funding level.

On the MDS assessment a certain code will indicate that the resident is at the appropriate level of care. MediCal funding is limited to residents who have impairments in cognition and/or physical functioning. I was trained and instructed as an MDS coordinator to code every federally and state funded patient as having physical and cognitive impairments that did not reflect the patient's actual condition, but rather would ensure payment to the facility.

I realized the significance of the tampering of the paperwork only when a private pay

patient who was paying in excess of $3,000 a month for care, ran out of private funding. She was informed that she needed to leave and find placement in a lesser level of care, because when her MDS was submitted with accurate information to MediCal for approval she was denied coverage because she did not meet federal and state funding guidelines.

Other types of patients are MediCare funded, such as those younger patients, who enter acute care hospitals after an unfortunate fall that leaves them with a hip or femur fracture. They require rehabilitative services, are sent to so-called "skilled" nursing facilities with intention of returning home soon. During the nursing home's initial admission assessment, the discharge planning goal for these residents is charted as *long term care*, in conflict with the patients', physicians' and families' goals to return home quickly. At the direction of my Director of Nursing, I frequently charted in this fashion.

MediCare Fraud

One very disturbing example of what in my opinion amounts to MediCare fraud involved a naso-gastric tube patient who was terminal from a massive cerebral vascular accident. She had 100 days of MediCare coverage because she had a naso-gastric tube inserted for nutritional support. During a care conference with the family, they requested to withdraw feeding because of the permanent irreversible damage to their mother. In the patient's advance directive her wishes were that her life not be sustained by artificial means, such as a feeding tube. I went to the Admissions Coordinator and was told this patient had 31 days left of MediCare, so we should wait until her MediCare funding was over. The wishes of the patient and her family were denied as a result of this calculated maneuver on the part of the nursing home administration. .

I would hope that the Senators in audience today will not be quick to judge these employees of long term care facilities. Like myself they may believe they are one of the few lights in the darkness, or may have been manipulated into believing there are limited funds available to the residents. In one extreme case, a plea came from the owner in a staff meeting to convince the staff that funding was so poor that as a dedicated and caring owner, he had to take out a second mortgage on one of his million dollar homes to make payroll! He was lying and deceiving the staff as revealed during trial testimony. These same underpaid caregivers are at times your family's only access to a fresh bar of soap, shampoo and love not provided by the facility. They use their own money to buy diapers, soap, shampoo and even clothing for the residents, when in fact, the monthly gross income from MediCare and MediCaid billings alone were hundreds of thousands of dollars a month.

Conclusion

In conclusion of this difficult testimony, I would like to thank you Senator Grassley and Members of the Committee for having this heart-wrenching and yet terribly overdue investigation and hearing. I would challenge each of you to remember our elderly and protect the rights of forgotten, silent, and perhaps non-voting contributors of our society. It is my belief that we would never tolerate these conditions in nurseries and day care

centers care for our children. We must object to this horrific mistreatment of our parents and grandparents.

The CHAIRMAN. Thank you, Ms. Lloyd.
Dr. Locatell.

STATEMENT OF KATHRYN L. LOCATELL, M.D., SACRAMENTO, CA

Dr. LOCATELL. Hello, and thank you so much for inviting me to be here. I am really pleased to be able to talk about some of the things that I can contribute based on my knowledge. I would like to clarify, though, that I am no longer employed as a faculty at the University of California. The funding for my position and my programs was cut recently.

I received some questions from you, Senator Grassley, about prevalence of decubitus ulcers, urinary tract infections, et cetera. I would like to go through some of these items.

In regard to the existence and prevalence of decubitus ulcers, they are incredibly common still. In a relatively small practice, while I was employed by the university over the past year, I have seen two Stage IV decubitus ulcers to the bone. These wounds are entirely preventable. There is never a reason that a patient should suffer from this type of wound if they are just getting adequate nursing care. In both of these cases, the patients were totally dependent on the staff to provide all of their needs because of disabilities.

In both of these cases, review of the chart indicated that the care had been provided. They had been turned every 2 hours, if you look at the nursing chart. There is no way they could have developed these wounds and had received the care that was charted in their record. In both of these cases, the patients died either directly or indirectly as a result of these wounds.

Regarding malnutrition and dehydration. I have had many, many of my patients experience unexplained weight loss. Unexplained. Unexplained means, gee, look at the chart, they are eating 83 percent this week. They ate 79 percent last week of a full portion. There is no medical way that these people could lose weight while consuming the amount of food that is documented. In the past 2 years, I have had one of my patients die from dehydration. Totally preventable.

Regarding fractures. I have seen one unexplained, again, unexplained fracture. This patient was virtually a quadriplegic from multiple strokes. The only way she could have suffered this fracture was from some type of trauma and, yet, in the nursing record there was no indication that anything had happened to this patient at all. It was simply observed that the leg was swollen and angulated.

She was sent to the emergency department. The emergency room physician filed an elder abuse report, as he was mandated to do because this is elder abuse. However, the medical director of the nursing home called me and asked me to call that physician and get him to retract his report because, as she put it, we both know these things happen all of the time. Indeed, they do, and they do constitute elder abuse. I have seen it in the last 2 years.

Urinary tract infections are ubiquitous in nursing home practice. The main causes are inadequate hygiene and inadequate fluid intake. These are, to a large extent, preventable as well. But what

is even more preventable is the urinary sepsis that develops when the symptoms go unrecognized. Understaffed, untrained personnel call me when the patient is so critically ill that they need to go to the hospital and spend a couple of weeks there, resulting in a downward spiral that many of them never recuperate from. The earlier subtle signs and symptoms are missed. So it is not until the patient is floridly ill that they actually get attention and treatment.

What are some of the underlying reasons for the development of these very painful, disabling, and inhumane conditions? You have heard it over and over again today—inadequate staffing. Inadequate staffing. There are not enough bodies to provide the care that these people need.

In the facility where I am medical director, the administrator budgets for temporary staff, and will fill in when people do not show up. The temporary staff, however, is particularly unreliable because they have no accountability. They go from facility to facility. So even the temporary staff it is a body to do the work. In the poorer quality facilities, the staff that call in sick or do not show up, are not replaced, and this happens over and over again.

Another major reason, inadequate training of staff. These people, as has been mentioned, are hired at minimum wage with very little training among the nursing staff, the licensed nurses. Patients are being sent out of the hospital—you may have heard this term—quicker and sicker. They are being sent out of the hospital quickly to the nursing home. The conditions of these patients are far different than 10 years ago, and the training and the demands of the staff has not kept up with the acuity level of these patients.

Another reason, inadequate compensation of the staff. Minimum salaries are the rule for personnel in nursing homes. Most will eventually leave for better pay and better working conditions.

Lack of leadership. Administrators, directors of nursing, and medical directors all share the responsibility for poor care. Medical directors are primarily figureheads. We really have very little say in how the business is conducted.

When I was asked to participate in preparation for the survey by the Joint Commission, I reviewed the credentials of physicians practicing in my nursing home, and I was really astounded to find out that one had been trained as a pediatrician in another country and had set up a general practice taking care of nursing home patients. Several of them had no training in adult medicine. They had no foundation for taking care of the common conditions that afflict these patients.

Directors of nursing and administrators are more concerned with running a business, and they are out of touch with the care. They are concerned with passing the surveys. When they take such a narrow approach, it pays dividends. They pass. The perception is that the care is adequate. We passed the survey and, as was pointed out, all of the dressing that goes on in preparation.

Finally, underlying reasons for all of these conditions: Lack of oversight and enforcement on the part of the regulators. I would like to tell you about the experience I had when I reported an elder abuse case.

An elderly Vietnamese woman who could speak no English was placed in a nursing home when her family could no longer care for

her. I walked in the facility and, at 10:30 in the morning, found her tied in bed with a Posey vest, one of the kind that ties behind you, and around you, and down under the bed rails. In addition, her wrists were restrained. There was an overpowering smell of urine in the room, and a nurse's aide was present, and I said, "Why is she being restrained like this?"

"Well, she keeps trying to get out of bed. She is trying to pull off her colostomy bag." There were no orders for those restraints on her chart. I went to the charge nurse on duty. This is 10:30 in the morning in the middle of the week. Her nonchalance, her nonchalance was chilling. "Well, you know, we do not want her to get out of bed and fall. Well, she kept pulling off her colostomy bag." This was a terminally ill patient who was there for comfort care in a hospice program.

I reported it as elder abuse. I never got a call back from the state evaluator, never. The ombudsman went in over a week later, and by that time the patient had died. The Elder Abuse Prosecution Unit of the State Attorney General's Office looked at this case and has yet to file any charges. It is my understanding that not a single case of elder abuse has been brought against a nursing facility in California.

What makes this particular case so egregious, in my opinion, is the total lack of regard for this woman's comfort and dignity in the last days of her life. She could not speak English, she could not communicate, and she was being tied down for the convenience of the staff. This type of occurrence deserves the harshest punishment that we have, and it should not be tolerated.

Financial considerations drive a lot of what happens in nursing homes; specifically, efforts to maximize revenues for Medicare. Physicians rubber stamp these orders. These facilities cannot get reimbursement from Medicare unless physicians sign the orders. I allude to in my testimony patients who have used up all 100 of their days, in one case, for caring for Stage IV decubitus ulcers that the patient developed while in the facility, all 100 days were used up. I have seen this many times.

When I ask patients about the care they received in nursing homes, I am frequently told that they never saw a physician during their stay. Physicians are absentees in the nursing homes in the community—in my community.

What are some of the underlying reasons for the average physician's lack of participation in caring for nursing home patients? Lack of training. I know you have heard this before this committee. There is a horrendous lack of training in geriatric medicine today, 10 years ago, 20 years ago. It is only going to become a greater crisis.

Reimbursement for nursing home care is pitifully low. The orthopaedic surgeon may get $5,000 to repair the hip and take care of the patient. The nursing home doctor gets $50 to provide all of the care that patient needs throughout the recuperation in the nursing home. I think that is one reason why you are not attracting highly trained doctors to take care of patients in nursing homes. Fifty dollars a month.

Again, oversight and enforcement of the statutes is lacking. A physician in my community was prosecuted and imprisoned for

Medicare fraud for billing patient visits that had never been performed. Yet, when I talk to nurses in my nursing homes in my community, they say he was one of the better doctors that they encountered.

False charting. You have heard a lot about it. I am going to finish by showing you an example of false charting that was just fairly astounding to me, and I stumble across these things. I do not go looking for them. I am taking care of patients. I am reading their charts. I am reading the MDS and finding these things.

There is a poster there of a physician's history and physical. This woman was 86 years old, fell, suffered a hip fracture, was treated in an acute care hospital, transferred to a nursing home. The initial physician who provided her care was also the medical director of the facility. Because of insurance reasons I needed to assume this lady's care, and I saw her 2 days after this note was written.

If you look at this note, this is a form letter, this is a form note that is filled out in the nursing home. I do not know what level this physician would have billed Medicare for, for this evaluation. "Fell, broke hip. Normal, normal, normal. See the records from the other hospital. Diagnosis: Right hip fracture. Status post surgery: High blood pressure and anemia." There is something incredibly critical missing from this whole history and physical, and that is that the woman had severe uterine prolapse. Her entire uterus was sticking out of her body. This is a condition that affects aging women.

Your staffers, Senator Grassley, were kind enough to provide me with a prop. It is that cantaloupe. It is a little bit too big, but this thing was the size of a grapefruit, and you could see it by just a cursory lifting of her gown. He specifically goes out of his way on his H and P to write that the genital urinary examination is normal.

This entire record is fraudulent, not to mention the fact that the reason this lady fell is that she had been slowly bleeding over time from this prolapsed uterus, had become so anemic that her blood was down a half of its normal value. She was taking care of children in her home. She was providing day care for people in the neighborhood. When she fell, there were 3-year-olds in the home who covered her up with a blanket until adults could get there and call for help.

I mean, there was an incredible history behind what happened to this lady, and this is what we get. And this is why, when the families are calling saying, "Help us," they get no response from the physicians because this is the kind of thing you see, and this man was the medical director of this facility. It is one of the most cosmetically appealing and expensive in the community.

I do believe that the quality of care in California nursing homes I have practiced in needs improvement. I have cared for hundreds of nursing home residents over the past 4 years, and I have seen some incredibly excellent care by wonderful, dedicated professionals. I am taking care of nursing home patients because I love it, and I believe in it.

Some of my patients have had outstanding care, but are these occurrences aberrations that I have described or are they just the tip of the iceberg? I believe that they are not the tip of the iceberg.

The poor quality of care, indeed, represents betrayal of the trust of the individuals who live in nursing homes and of the taxpayers who must pick up the tab.

Thank you, again. I am sorry my remarks went over. I really appreciate your listening. Thank you.

[The prepared statement of Dr. Locatell follows:]

TESTIMONY OF KATHRYN L. LOCATELL, MD
Before the Hearing of the
UNITED STATES SENATE SPECIAL COMMITTEE ON AGING
"Betrayal: The Quality of Care in California Nursing Homes"
July 27, 1998

Senator Grassley and Members of the Committee:

Thank you for inviting me to discuss some of the grave concerns I have about the quality of care in nursing homes in California. I appear here today as a private citizen and practicing geriatrician who has had extensive experience with these issues over the past several years.

I have had a lifelong interest in caring for nursing home residents. My first job as a teenager was in the kitchen of a nursing home. Later, as a nurse's aide, I fainted during my first shift on the job while helping a nurse change the dressings on a patient with several massive, deep decubitus ulcers. My grandfather died of gangrene and sepsis from neglect in a nursing home. While these events took place in the 1970's, and measures have been attempted to improve the care for these vulnerable patients in the intervening years, I will explain in my testimony that conditions in California nursing homes today are equally alarming.

I intend to address the concerns posed by Senator Grassley in his letter to me, and they are as follows:

1. The existence, prevalence, and catalyst for malnutrition, dehydration, decubitus ulcers, urinary tract infections, fractures, burns and scalding experienced by residents in the nursing homes where you have visited patients;

2. The falsification of medical records, including a discussion regarding the accuracy of the Minimum Data Set, admission information, and care plans, as well as the motivation and process used to falsify data;

3. Your experience and opinion regarding the motivations of nursing home administrators, including a discussion about the use of ancillary services reimbursed by Medicare;

4. The approach of physicians to nursing home practice, including a discussion of the impact training and reimbursement have on the quality of physicians treating nursing home residents.

First, in regard to the existence and prevalence of decubitus ulcers, I find that they are still incredibly and unfortunately common. I have cared for hundreds of nursing home patients in the past four years. Since joining the faculty at the University of California my patient census in nursing homes has averaged 30 or fewer patients. However, within the past year, I have seen severe, Stage IV wounds develop in two of my patients, a

startlingly high prevalence. This type of wound is entirely preventable with adequate nursing care.

In both cases, the patients were totally dependent on nursing staff to meet their basic daily needs, and unable to communicate adequately due to stroke or dementia. In both cases, the nursing homes where these patients received care are among the better facilities in Sacramento, with a high proportion of private paying residents.

In both cases, review of nursing aide and licensed nurse charting revealed that the minimum requirement of repositioning the patient every two hours had been carried out. It is just not possible that these patients had been adequately repositioned. The reliability of charting in nursing homes is abysmal, and I will discuss this further.

In both cases the patient died, either directly or indirectly as a result of these wounds.

Next, regarding the issues of malnutrition and dehydration, I have had many, many of my patients experience "unexplained" weight loss and dehydration. On at least one occasion in the past two years, the dehydration was severe enough to result in death. Again, the charting of both nursing assistants and licensed nurses in these cases reflected "adequate" intake, with specific amounts of both food and fluids documented. It is not medically possible that patients could develop such weight loss or dehydration while having consumed the quantities of food or fluids recorded in the medical record.

Regarding fractures, I have seen one "unexplained" fracture in the past two years. The patient was virtually a quadriplegic from multiple strokes, and could only have suffered the fracture through some type of physical trauma. Yet the nursing and nurse assistant notes contain no explanation of how the fracture occurred. It was simply "observed" that the patient's leg was swollen and angulated. In this particular case, the emergency department physician who treated the patient filed an elder abuse report. The medical director of the nursing home subsequently asked me to call the physician and try to convince him to withdraw the report, because "we both know these things happen all the time". Indeed they do, and in my opinion constitute elder abuse.

Urinary tract infections are ubiquitous in nursing home practice. The main causes of these infections are inadequate hygiene and inadequate fluid intake. Many patients have subtle symptoms that go unrecognized by nursing personnel, and a doctor is called when the patient is floridly ill. Physicians rely on trained nursing personnel to report changes of condition, and yet when facilities are understaffed or staffed with temporary or inexperienced nurses, changes in the resident's status often go unrecognized until more severe symptoms develop. I can only estimate the number of patients I have treated for urinary sepsis that went unrecognized. Over the past four years, there have been scores. What are the underlying reasons for the development of these painful, disabling and inhumane conditions? In my opinion:

- Inadequate staffing. Casual conversation with nursing personnel in nursing homes where I care for patients invariably centers on workload. Nurse's aides routinely work double shifts. Licensed nurses vent their frustration with having their workload doubled when others call in sick or find employment elsewhere. In the facility where I am medical director, the administrator budgets for temporary staff, both licensed and unlicensed. However, temporary staff often proves unreliable and unaccountable for their performance, increasing the stress on permanent employees. But in poorer quality facilities, administrators fail to provide any additional temporary staff, expecting existing staff to simply increase their workload. This results in tremendous stress for the usual employees. It is often this type of stress that leads to neglect and abuse.

- Inadequate training of staff. " Inservices" are provided to many of the employees in nursing homes where I practice, yet the baseline knowledge of staff regarding geriatric nursing and common medical conditions is quite scant. The acuity of illnesses currently treated in skilled nursing facilities is far greater than even 5 years ago, and yet the skill level of staff is still geared toward conditions extant in the previous decade.

- Inadequate compensation of staff. Minimum salaries are the rule for personnel in nursing homes compared to acute care hospitals. Many of the best nurses leave for better pay and working conditions.

- Lack of leadership. Administrators, Directors of Nursing and Medical Directors all share the responsibility for poor care.
  - Medical Directors are primarily figureheads. They have little or no knowledge of or involvement in decisions about staffing levels or compensation. Few participate in operational decision-making in even a nominal way.

    When the facility where I am medical director was preparing for the Joint Commission on Hospitals and Accreditation visit for the purpose of certification, I was asked to review the credentials of physicians practicing in the facility. I was astounded at the credentials of some of these physicians. One had been trained in pediatrics in another country, had become licensed here, and started a general practice including caring for nursing home patients. Another individual's file revealed two years of training in orthopedics; this physician has subsequently developed one of the largest nursing home practices in the community, and is medical director at another of the facilities in the non-profit chain that includes mine. Another was trained in radiology, yet another in vascular surgery and both of these individuals had also developed sizable nursing home practices.

    When doctors lack training in adult medicine, as in these cases, they have no foundation for treating such common conditions as diabetes, hypertension, heart

disease, and dementia to name a few. When I voiced my concerns to corporate administrators, my suggestions were met with extreme unease. I was basically told that I could not exclude these physicians. I did end up declining to credential several physicians with no training in adult medicine.

- Directors of Nursing and Administrators are concerned with running a business and are out of touch with the care being provided. They tend to concern themselves with making sure regulatory requirements are fulfilled. Taking such a narrow focus often pays dividends in terms of passing state surveys – leading to the perception that the care provided is adequate.

- Lack of oversight and enforcement on the part of the regulators. When there is little or no attempt by regulatory agencies to evaluate and enforce compliance with State and Federal law, it is not surprising that nursing facilities continue to provide inadequate and inhumane care.

Last fall I visited a terminally ill patient who had been placed in a nursing facility when her family could no longer provide the care she needed at home. She was a Vietnamese immigrant who spoke no English, who was dying, and who had no way to communicate her needs to the staff. At 10:30 in the morning I was astounded to find her in bed, tightly restrained with a Posey vest on and wrist restraints in place. The smell of urine in the room was overpowering. A nurse's aide was present in the room with the resident. I asked her why the patient was restrained, and was told, "she keeps trying to get out of bed and remove her colostomy bag". There was no order for such restraints on her chart. When I confronted the charge nurse on duty, I was met with a nonchalance that was chilling.

I filed an Elder Abuse Report with the county Ombudsman's Office, as well as a complaint with the state Department of Health Services. In spite of numerous attempts to speak with a nurse evaluator, I never received a returned phone call. The Ombudsman's office was unable to substantiate the complaint *because the patient had died* before the representative visited the facility, about one week after the incident. I later discovered that the facility had been issued a Class "B" citation for the use of illegal wrist restraint as a result of my complaint. The Elder Abuse Unit of the California State Attorney General's Office investigated the complaint, but has not yet filed criminal charges. It is my understanding that this unit has never prosecuted a single case of elder abuse occurring in nursing homes.

What makes this particular case so egregious in my opinion is the total lack of regard for the patient's rights and comfort, with the restraints placed solely for the convenience of the staff. This woman suffered untold misery as a result of being violated in this way during the last days of her life. This type of occurrence deserves the harshest punishment we have, and should not be tolerated.

Financial considerations drive many of the practices in nursing homes. I would like to comment specifically about two areas of concern: efforts to maximize revenues from Medicare, and the role physicians play in facilitating these efforts.

There is no question that nursing facilities try to maximize reimbursement from Medicare. I see this particularly in cases where patients receive benefits under Part A. The average physician caring for patients in nursing homes in my community will automatically rubber stamp all care being provided. Patients are treated until Medicare days are exhausted. On numerous occasions over the past several years I have treated patients who have spent all one hundred days of their benefit in a single post-hospital nursing home stay for highly questionable indications.

One gentleman who was discharged to a skilled nursing facility for rehabilitation following knee replacement surgery spent 100 days receiving care for Stage IV decubitus ulcers *he developed while a patient at the facility.* He subsequently received rehabilitation services under Part B while paying privately to stay in a nursing home, and was able to regain independence and return home. Again, the average nursing home doctor will continue to sign the orders and visit every 30 days while taking no active role in directing the patient's care, as was the case for this unfortunate man.

When I ask patients about the care they received in nursing homes, I am frequently told that *they never saw a physician* during their stay. Physicians are absentees in nursing homes in this community and yet they perpetuate some of the financial abuses by virtue of their absentee approach. As long as the doctor rubber stamps the facilities' requests for services they have carte blanche to bill Medicare for as much as they can. Part B services are also frequently requested by the facility and authorized by the physician, for such things as "caregiver training" to the nurse's aides, and evaluations by therapists for "proper wheelchair positioning" – items that certainly can and should be provided as part of usual care.

What are the underlying reasons for the average physician's lack of active participation in caring for patients in nursing homes? In my opinion:

- They have little or no training in geriatric medicine. This is a well-recognized problem in medical education, with prospects looming for an even greater crisis, given the expected growth of the older population in coming decades.
  - A very small percentage of residents in training have received any exposure to nursing home care in medical school. The vast majority has never even been in a nursing home.
  - Judging from my review of the credentials of physicians practicing in the nursing facility where I am medical director, at least 50% have received only one year of

post-graduate medical training, the bare minimum required for state licensure. Again, this amount of training does not qualify physicians to care for this population.

- Reimbursement for nursing home care is pitifully low. For approximately $50 per month, the physician is expected to provide all needed services, 24 hours a day, seven days a week, to some of the sickest and frailest individuals he or she will ever encounter. Much of the care is provided by telephone or fax communication, which are not reimbursable services.

- Again, oversight and enforcement of statutes is lacking. When a physician in my community was prosecuted and imprisoned for committing Medicare fraud in billing for nursing home services, I was told by several nurses who had worked in long-term care for many years that "he was one of the *better* doctors" they see in their facilities!

Finally, I would like to touch on the issue of falsification of records in the nursing home. This problem is so serious that an entire hearing should be devoted to it alone.

False charting occurs on a daily basis in every nursing home I have visited. It is particularly common in nurse's aide charting. Because so much of the nursing home's reimbursement and permit to operate depend on charting, no spot can be left blank. It is preferable to fill in anything, rather than imply the care was not provided or the condition not observed. There are a number of indications that the charting is false.

First, the charting directly conflicts with either what I have observed or been told by a reliable patient or family member. For example, I observe that the patient's dentures are in dire need of cleaning. The patient is unable to do it alone and tells me that they haven't been cleaned since admission. However, the daily care record shows initials present, indicating the care had been provided on every single day, when clearly it had not.

Second, contradictory statements are found in the record, e.g., the licensed nurse's note states patient lethargic with poor oral intake, while the nurse's aide record shows "100%" of fluids were consumed during the same shift. Similarly, large amounts of weight loss occurred while the record documents "90%" or "100%" of each meal has been consumed.

It is particularly common to find discrepancies between the information contained in the Minimum Data Set (MDS) and the clinical charting. Recently one of my patients moved to a new facility. Because I had concerns about the quality of care in the new facility, I read the chart rather carefully. I was surprised to find in the MDS that the patient was considered to be totally dependent for ambulation, while previously she had been ambulatory with a walker. Her husband confirmed that, indeed, she was just as able to walk with her walker as ever. Restorative nurse's aides worked with her three times

weekly and charted her walking with standby assistance only, which surely places her at a higher level of independence than the entry in the MDS would indicate. In general I would estimate that the information contained in the MDS is accurate only about 50% of the time.

Third, on occasions when I have assumed the care of patients from other physicians, I have seen outrageous examples of false or fraudulent documentation.

For example: an 86 year old woman fell, suffering a hip fracture. She is transferred to a skilled nursing facility for rehabilitation under the care of Dr. A, who also happens to be the medical director of the facility. I assume her care the next day because of insurance requirements (she belongs to a Medicare HMO, contracted with UCDavis).

Dr. A's initial history and physical states that he has reviewed the hospital's records, and interviewed and examined the patient. He specifically charts that her physical examination is "normal", specifically including her genitourinary examination as "normal". Each and every record sent to the nursing home from the hospital regarding this patient refers to "severe uterine prolapse", and when I examine the patient I find that this uterine prolapse is impossible to miss upon an even cursory lifting of her gown. Therefore, *Dr. A's entire entry* into this patient's chart constitutes falsification. He did NOT review the records OR examine the patient as he states he did in his note. Incidentally, this nursing home is one of the most expensive and cosmetically appealing in the community, and its medical director is probably committing this type of fraud on a regular basis!

In conclusion, I do believe that the quality of care in the California nursing homes I have practiced in needs improvement. I have cared for hundreds of nursing home residents in nearly every nursing home in Sacramento over the past four years. Some of my patients have received outstanding care from dedicated professionals in excellent facilities. But are the occurrences I have described today aberrations, or the tip of the iceberg? I fear they are the latter. The poor quality of care indeed represents betrayal, of the trust of the frail elderly who must live in them and of the taxpayers who pick up the tab.

I would again like to thank Senator Grassley and Members of the Committee for allowing me to share my concerns with you. As a physician and concerned citizen, I urge you to continue your investigations with the goal of finding solutions to some of these pressing problems.

CHIEF COMPLAINT

(R) hip fx S/P ORIF

HISTORY

86 y/o ♀ fell / fractured (R) hip - operated - now "scooting" c PT/OT

REVIEW OF SYSTEMS

skin - WL - some recent bruises

HEENT - ↓ SX
Resp - ↓ cough
Heart - ↓ pain
GI - NO SX
GU - WL

PHYSICAL EXAMINATION

All H&P Px from Nancy Solomon dated 3-5-98 & 3-6-98

HEENT - WL
Lungs - clear
Heart - RR
Abd - normal BS
GU - WL
Ext - ↓ edema - Tel Hose - wearing (R) leg

ORAL ASSESSMENT, COMMENT ON THE CONDITION OF ORAL CAVITY, TEETH AND TOOTH, SUPPORTING STRUCTURE:

good

SKIN CONDITION:

good

NUTRITION/HYDRATION STATUS

good

MENTAL STATUS

good

RESIDENT IS FREE OF COMMUNICABLE DISEASES INCLUDING ACTIVE TUBERCULOSIS YES ☒ NO ☐

ALLERGIES

None known

PRIMARY DIAGNOSIS

(R) hip fracture S/P ORIF

SECONDARY DIAGNOSIS

HTN / anemia ? G.I. bleed

PHYSICIAN'S SIGNATURE

X

DATE

3-19-98

Resident's Name (Last, First, MI)	Attending Physician	Room Number	I.D. Number
		105A	98059

MEDICAL HISTORY/PHYSICAL EXAMINATION

FMC-1115 (12/

50-900

PATIENT PLATE

UNIVERSITY OF CALIFORNIA DAVIS
MEDICAL CENTER
SACRAMENTO

SNF

OPD PROGRESS RECORDS

Adm 3/9/98

d.o.b. ~~3/0/98~~ 9/1

NOTE PROGRESS OF CASE, COMPLICATIONS, CONSULTATIONS, CHANGES IN DIAGNOSIS, CONDITION ON DISCHARGE, INSTRUCTIONS TO PATIENT.

APPOINTMENT TIME:

ARRIVAL TIME:

3/12/98 lt arm fixed

86 yo SIF R hip fx 3/5/98 → [illegible]
hospital hemiarthroplasty. Needed
to have Fe def. anemia. Patient's Hgb 6.2
MCV 60. [illegible]
[illegible] Pain [illegible]
[illegible] Hgb [illegible]

A-ED RP [illegible]

Ed [illegible] NPO

Lungs CTA

RUE [illegible]

[illegible]

Impaired nerve conduction (complete)

[illegible]

Extremities

Last Hgb 7.9 5/11.7

A/P 86 yo [illegible]
Fe def. anemia
Pt did not but I feel benefit > risk
for CVA prevention
Will need CT W/U if aneros
↓ HCT 2° to perirenal uremia
✓ anacheck

Located

DEPARTURE TIME:

71431-199 (10 88)

PROGRESS RECORD
(O.P.D.)

White: Medical R
Canary: Departm
Pink: Billing

The CHAIRMAN. I am going to bring the other witness in. So will you three people stay at the table. We should hear the fourth one before we ask you questions.

I would like to, at this point, notify the press and TV that because we are going to have a witness that is testifying behind a screen, it is imperative that we protect her identity. In keeping with that commitment, I would ask the following: That C–SPAN please unplug the camera that would be behind me in the wall and that all cameras on the second floor please turn your cameras away. Turn the lights on so that we can see the cameras. The point being that you simply cannot film during part of the second panel.

Then I would like to say a word to our witness, whose identity the committee is obligated to protect. This committee appreciates and recognizes the public service that this witness is performing by coming forward. It cannot be overstated how important her testimony will be. She is providing us with the kinds of insight and understanding that can only come from insiders, and I might add that insiders who care about making a difference.

Sadly, it often happens that those who come forward under these circumstances are the targets of retribution by employers, and I sincerely hope that that does not happen in this case. If it does, let me assure our witness that this committee will take whatever steps are necessary to protect that and stop that.

18 U.S. Code 1505 makes it a crime to impede a congressional investigation. In that regard, I would consider it an impediment to include retaliation against committee witnesses.

Again, I thank this witness, whom we are going to refer to as Florence N, for coming forward and for acting in the public interest and in the interest of thousands of nursing home residents and their families. She is currently a health facilitator and nurse evaluator, known as a surveyor, with the California Department of Health. She is here to tell us about how the survey and the certification process of nursing homes is flawed and, at times, fraught with corruption and cronyism.

I would ask for your testimony, Florence N. Would you start, please.

STATEMENT OF FLORENCE N, REGISTERED NURSE

FLORENCE N. I feel privileged to have been invited to participate in this special committee hearing on aging. I thank you for the opportunity to provide the testimony and to be of service.

I am a licensed registered nurse within the State of California. In my current position, it is my responsibility to survey and monitor health facilities for compliance with State and Federal regulations, write reports, investigate complaints regarding patient care and services, issue citations when indicated, investigate adult/elder abuse, assist providers with clarification of regulations. I continue, at this time, as a health facilities evaluator nurse with the State of California. I have substantial experience and service in the nursing profession.

As a surveyor in the skilled nursing facilities, my experience has been both a very rewarding experience, but also a very frustrating process. The reason is because we have regulations to go by, but sometimes we cannot enforce the very regulations that are violated.

The final decisions regarding the determinations of the survey team are made by supervisors and administrative staff that may not have a medical background or current training.

In California, the typical survey is conducted by a team of three to four surveyors, depending on the size of the facility. One person is designated as a team leader or team coordinator, and that person usually handles the paperwork involved.

A team may consist of three RNs and one generalist or all RNs. The generalist focuses on the environmental and physical plant issues, while the RNs focus on medical issues. Sometimes the generalist is also a licensed nurse and does both tasks accordingly.

The first thing we do before we go out on a survey is an offsite prep. In this task, we review the previous survey to get an idea of the possible deficient practices and history of the facility. We review computerized reports—OSCAR and ODIE—with data that goes back at least 3 years, so we have a fairly good idea of how that facility performs. There are some good-performing facilities and poor-performing facilities. The team coordinator then assigns the tasks to be done to the team members. Then every team member knows what they have to do.

When we get to the facility, the team divides up, and we all go in different directions We tour the facility and get an overall view of the status of the residents. Next, we meet and select our survey sample based on our observations, information gathered from the tour and from the facility staff.

Once the sample of survey is chosen and we have agreed on what care needs we are going to focus; for example, restraints, pressure sores, weight loss, et cetera, we proceed with medical record reviews while keeping our eyes and ears open to the surroundings. We discuss our concerns with the facility staff as we go so that there are no surprises at the end of the survey.

The survey is divided into two phases. In Phase I, we do a certain number of comprehensive reviews of the medical record. In Phase II, we do focused reviews, keeping our attention on those focused issues identified in Phase I, or new issues identified in Phase II.

When all the survey tasks are complete, we have an exit conference and advise the facility of our findings. Then we write a report regarding the deficient practices and wait for a written response and a plan of correction.

We try to write our report in a manner that is most beneficial to the residents. We give our deficient findings a score based on scope and severity. Sometimes money penalties are assessed as a remedy to the deficient practices.

The specific shortfalls that plague the system are:

No. 1, the appointment of administrative staff to run the Department of Health Services who do not have a medical background or medical education. They make all the decisions regarding the health care of the elderly. The medical professionals are not always involved in making the final determinations regarding the health care of the elderly in California.

No. 2, the focus is no longer on patient care. The focus appears to be on warehousing the elderly, running the facility as cheaply as possible with inferior products, such as soaps, linens, and over-

working the CNAs at lowly wages and double shifts. There are times that CNAs are so tired that they are not able to give appropriate care and accidents result. The residents sustain fractured bones, and they are the ones that end up suffering and paying the price. The residents have accidents in bed and sit in their urine and feces because the call lights are not answered promptly.

No. 3, allowing the medical director of a facility to be the attending physician for as many as 80 to 90 percent of the total population of that facility. In some cases, the physician does not get to know the patients, let alone provide adequate care. When the patient suffers or declines in medical status, there is no one above that medical director/attending physician to provide the necessary treatment and services. The resident continues to go down hill and dies.

In one case, a resident went to a facility for physical therapy after a little stroke. He died within 3 months from urinary tract infection and pneumonia that went untreated for over 24 days. He lost 19 pounds in 1 month.

No. 4, the State citations and penalties assessed are often reduced to a lower level of severity and to a reduced amount of money because the facility's attorneys complain to the Department or negotiate a settlement at the expense of the patient or the families. I do not know how the State citations and penalties are enforced, but it appears that many of the penalties are never collected, and the facility continues to operate their business as usual.

No. 5, some State regulations are antiquated and have not been revised for years. The regulations are the minimum requirements and do not reflect the current needs of the elderly in today's society. In many cases, the regulations are so out of date they are obsolete and nonapplicable. Revising the State regulations does not appear to be a priority in California. In some cases, some physicians come to the facility at night and never see the residents, but they chart as if they had seen them.

No. 6, the survey teams in the skilled nursing facilities do not usually involve physician consultants unless there is an "A" citation to be issued. In those cases, the support the team receives from the physician consultant appears to depend upon which facility is involved. In some cases, there have been interventions in the decisions that are made at the Citation Review Conference, called a CRC, and those interventions have reversed the results of the hearing officer's decision.

Many citations are dropped for lack of support from the physician consultant, and the families are left with no satisfaction, and they wonder if the process is effective and just.

The impact that influence, preferential treatment, cronyism and favoritism have upon surveyors is that it instills a feeling of frustration, hopelessness, and anger because it negates the intent of the process to regulate and provide appropriate, safe care for the patient. The effort is spent for naught. The providers continue to take advantage of the system at the expense of the patient. Eventually, the surveyors become so complacent, they do not bother to react to the situation and all of the findings are classified as unsubstantiated when, in fact, the opposite is true. The surveyor gives up and asks, "What is the use?"

It is obvious that there is favoritism within the ranks. Some people get promoted several times in a short period of time, while others equally qualified remain in the same position for years.

The existence, prevalence and catalyst for malnutrition, dehydration, decubitus ulcers, urinary tract infections, fractures, burns and scaldings experienced in nursing homes I have inspected is the low nursing staff-to-patient ratio requirement. The requirements are minimal and totally inadequate for today's population in the skilled nursing facilities.

The acuity of the patient in the skilled nursing facility is much higher than it used to be. The patients are more acutely ill and require more than custodial care. The facility can manipulate the staffing figures to meet the requirements, but that does not mean that the staffing is adequate at all. For example, the facility has four licensed nurses in 24 hours. The nurses' hours are counted twice. The facility can say that they had eight nurses when, in fact, they only had four nurses in 24 hours.

Time and time again, the most prevalent complaint from residents in nursing homes or their families is the shortage of staff. Some family members feel compelled to spend every possible moment with their loved ones for fear that he or she will not get cared for. The family member ends up; getting sick from the stresses as a result of having their loved one in the facility and the staffing shortages.

In addition, a current problem in California is the inadequate training of the CNAs, (certified nursing aides), that they are receiving through the facilities that provide the CNA training programs. There are only three RNs overseeing the CNA programs in the whole State of California. The facilities are getting automatic renewals for the programs. There are no provisions for program site visits to ensure that the provider and the program is in compliance with the regulations or the facility's own policies and procedures. It is impossible for three RNs to monitor the State's many facilities.

Another problem is the requirement of dietary services provided by the registered dietician to the skilled nursing facilities. There are some providers who have as many as 14 facilities for one dietician. It is impossible for one dietician to oversee the nutritional status of 1,400 residents if each facility has 100 residents. Some facilities have as many as 250 residents.

The dietary supervisors are not adequately trained to monitor the nutritional requirements of the patients. Significant weight losses and dehydration are sustained by residents before any interventions are implemented by the facility. By the time the dietician gets to the problem, it is too late. The resident may die from dehydration, or breaks down, develops pressure sores which never heal, and result in sepsis and death.

It is difficult to choose a worst case of neglect in California nursing homes that I have inspected. I have seen residents with Alzheimer's Disease who were beaten to a pulp, and their facial bones were all fractured by another resident when the resident wandered into the aggressor's room.

I have seen residents who were malnourished, developed Stage III and Stage IV pressure sores that never healed, became infected, and the resident died of sepsis. I have seen instances where the

resident fell, fractured her arm, went to surgery, and died within one week from complications related to the initial fall.

While the entire facility staff, except for one licensed nurse who was overseeing 90-plus residents, all were attending an in-service regarding falls, another resident fell, left the facility in her wheelchair and was found outside the parking lot bleeding from scalp lacerations. 911 was called by a member of the church across the parking lot, who confirmed that the resident was out of the facility, found, assisted, and transported to the acute care hospital before the facility was aware that the resident was missing.

I have seen instances where the attending physician of 80 percent of the SNF's population was also the medical director of the facility. The residents under the care of that physician were so neglected many had significant weight losses, infections and died as a result from lack of intervention and care by the physician.

In spite of the family's request to transfer the patient to the acute care, the facilities stated that they were able to take care of the patient, and he continued to decline and within 3 months the resident died.

One of the worst cases of neglect in a California nursing home is where an abusive resident was allowed to beat five female residents overnight. The facility failed to do anything about the situation until the surveyor intervened. The five female residents were in the Alzheimer's unit, so the facility thought that it was all right to allow the residents to get beaten up because they, the female residents did not know what was happening anyway.

We had to call a serious and immediate threat before the facility would protect the residents from further harm. Those residents who have no family to visit them are the most vulnerable to neglect because there is no one to oversee their care. The residents are often intimidated by the facility and are afraid to voice grievances.

My experience and opinion regarding the motivation of nursing administrators is money, and I emphasize money. This is a lucrative business, and it is not done for free. Most administrators do not invest money back into the facility. Many times the residents are observed in tattered and ill-fitting clothing. Their hair is matted and dull because shampoo and conditioner are not used to wash their hair. The facilities use a generic soap for shampooing as well as showering. The washcloths are paper thin and inadequate. The quality of patients' care is diminished. In some cases, nursing home administrators have an attitude that the resident goes into the nursing home to die, when, in fact, many go there for convalescence and rehabilitation. Many residents plan to get well and return to their homes.

Most nursing homes have a facade that is disarming and is set up in appearance to influence to bring their loved ones there. Once past the big double doors, it is a different story, all business and very dismal. They rush the patients through their meals, yell at them when they are confused and insecure, and they treat them like children. They strip all of their dignity from them.

Last, the California health facility provider association is very powerful in California. Sherrie Crumm meets with the Deputy Director of the Department of Health Services and other department heads every 2 weeks. All of the policies and procedures are over-

seen by the representative for the providers before they are implemented. Sherrie Crumm does not work for the Department of Health Services, but is basically making the decisions for the Department of Health Services.

That is all I have to report. Thank you.

[The prepared statement of Florence N. follows:]

STATEMENT
by
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In California, the typical survey is conducted by a team of 3-4 surveyors depending on the size of the facility. One person is designated as a team leader or team coordinator and that person usually handles the paperwork involved. The team may consist of 3 RN's and one generalist or all RN's. The generalist focuses on environmental and physical plant issues, while the RN's focus on medical issues. Sometimes the generalist is also a licensed nurse, and does both tasks accordingly.

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Once the sample of residents is chosen and we have agreed on what care needs we are going to focus on, i.e. restraints, pressure sores, weight loss, etc., we proceed with medical record reviews while keeping our eyes and ears open to the surroundings. We discuss our concerns with the facility staff as we so that there are no surprises at the end of the survey.

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a. The appointments of Administrative Staff to run the Department of Health Services who do not have a medical background or medical education. They make all the decisions regarding the health care of the elderly. The medical professionals are not always involved in making the final determinations regarding the health care of the elderly in California.

b. The focus is no longer on patient care. The focus appears to be on "warehousing" the elderly, running the facility as cheaply as possible with inferior products, i.e. soaps, linens and overworking the CNA's at lowly wages and double shifts. There are times that CNA's are so tired that they are not able to give appropriate care and accidents result. The residents sustain fractured bones and they are the ones that end up suffering and paying the price.

c. Allowing the Medical Director of a facility to be attending physician for as many as 80-90% of the total population. In some cases, the physician does not get to know the patients, let alone provide adequate care. When the patient suffers or declines in medical status, there is no one above that medical director/attending physician to provide the necessary treatment and services for the patient. The resident continues to go down hill and dies.

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The existence, prevalence and catalyst for malnutrition, dehydration, decubitus ulcers, urinary tract infections, fractures, burns and scaldings experienced in nursing homes I have inspected is the low nursing staff to patient ratio requirement. The requirements are minimal and totally inadequate for today's population in skilled nursing facilities. The facility can manipulate the staffing figures to meet the requirements, but, that doesn't mean the staffing is adequate at all.

For example, the facility has 4 licensed nurses in 24 hrs. , the nurses hours are counted twice. The facility can say they have 8 nurses when, in fact, there are only 4 nurses in 24 hours.

Time and time again, the most prevalent complaint from residents in nursing homes, or their families, is the shortage of staff. Some family members feel compelled to spend every possible moment with their loved ones for fear that he/she won't be cared for. The family member ends up getting sick from the stresses as a result of having their loved one in the facility and the staffing shortages.

In addition, a current problem in California is the inadequate training the CNA's (Certified Nurses Aides) are receiving through those facilities that provide CNA training programs. There are only 3 RN's overseeing the CNA programs in the State of California. The facilities are getting automatic renewals for the programs. There are no provisions for program site visits to ensure that the provider and program is in compliance with the regulations or the facility's own policies and procedures.

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residents who were malnourished, developed Stage III and Stage IV pressure sores, that never healed, became infected and the resident died of sep sis. I have seen instances where the resident fell, fractured her arm, went to surgery, and died within a week from complications related to the initial fall. While the entire facility staff (except for one licensed nurse overseeing 90+ residents) were all attending an inservice regarding falls, another resident left the facility in her wheelchair and was found outside in the parking lot, bleeding from scalp lacerations. 911 was called by a member of the church across the parking lot who confirmed that the resident was out of the facility, found, assisted and transported to the acute care hospital before the facility was aware that the resident was missing. I have seen instances when the attending physician of 80% of the SNF's population was also the medical director of the facility. The residents under the care of that physician were so neglected, many had significant weight losses, infections and died as a result from lack of intervention and care by the physician.

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We had to call a "serious and immediate" threat before the facility would protect the residents from further harm. Those residents who have no family to visit them are the most vulnerable to neglect because there is no one to oversee their care.

My experience and opinion regarding the motivation of nursing home administrators is MONEY. This is a lucrative business and it is not done for free. Most administrators do not invest any money back into the facility. Many times the residents are observed in tattered and ill-fitting clothes. Their hair is matted and dull because shampoo and conditioner are not used to wash their hair. The facilities use a generic soap for shampooing as well as showering. The wash cloths are paper thin and inadequate. The quality of patient's care is diminished.

The CHAIRMAN. We thank you very much. We will go to questioning now. So if each of you would stay, as inconvenient as it might be for us to have eye contact on occasion, stay where you are, and we will ask you questions accordingly

First of all, Dr. Locatell, when did you say your position at the University of California, Davis, ended?

Dr. LOCATELL. June 30 of this year.

The CHAIRMAN. And it was strictly related to funding.

Dr. LOCATELL. Funding cut, yes.

The CHAIRMAN. It had nothing to do with your interests in nursing home welfare?

Dr. LOCATELL. I have my suspicions about that.

The CHAIRMAN. Well, then tell me about your suspicions because I am interested in anybody who would be punished for looking out for the welfare of people in nursing homes and, more importantly, people who would be just expecting laws, and regulations, and policies to be abided by.

Dr. LOCATELL. Well, I was recruited to the faculty, and one of the things that I felt really needed to be done was a nursing home program to educate residents. There were no other faculty in geriatrics or in any other area who were taking on this area.

My position at the time was that we needed to go to high-quality facilities; that we should not send our patients to the types of facilities that you have heard about today. We all know which facilities those are and, yet, there was a financial arrangement with one of the most notoriously awful facilities across the street from the University Medical Center. They were sending 30 patients a month there. Fifteen of them came back every month. In the 6 months that I developed my program, less than 10 percent came back to the hospital, none needed emergency room care. These were from high-quality facilities, where you could rely on the nursing staff, you could rely on what was provided there and, yet, the university repeatedly was sending patients to this place across the street.

It is very complicated why they were doing that, but there was clearly a financial arrangement with the owner of that facility, which is a for-profit facility, and I was extremely vocal about this during the course of my 18 months on the faculty. I had received a merit promotion with a unanimous vote. Three months later the funding is cut for my position.

The CHAIRMAN. And you would have had expectations to be there for a long, long period of time under the tenure arrangements of most universities.

Dr. LOCATELL. Well, I was not in a tenured position, but, clearly, more geriatricians, more clinical geriatricians are needed to train residents, and I was recruited to join the faculty. The residents loved the rotation. They were learning something. And to have the position cut, coincident with some other things that had to do with my objections to this nursing home, I find to be very suspicious.

The CHAIRMAN. Would you be cooperative, if I wanted to look into this further with you?

Dr. LOCATELL. Most definitely.

The CHAIRMAN. And on your behalf?

Dr. LOCATELL. Most definitely. Thank you.

The CHAIRMAN. Thank you very much. I think I will continue questioning you, not about this matter, but on to more of the testimony that you had today.

You make many important points in your testimony about the importance of professional medical training in geriatric care, and I wanted to point out to you that the Aging Committee held a forum on this very issue earlier this year, at which it was argued that there is an undersupply of geriatricians in our country.

As a practicing geriatrician, you, of course, are well qualified to answer questions on the medical care and nature of older adults. With that in mind, these set of questions will come. Obviously, there are exceptions to each question, but please answer with a simple yes or no, if that is possible.

Is malnutrition preventable and treatable for nursing home residents who are not suffering from wasting type diseases?

Dr. LOCATELL. Yes.

The CHAIRMAN. Is dehydration preventable and treatable for nursing home residents who are not suffering from wasting type disease?

Dr. LOCATELL. Most definitely, yes.

The CHAIRMAN. Are pressure ulcers preventable and treatable for nursing home residents?

Dr. LOCATELL. They are entirely preventable. They may not always be treatable. Once they have developed to the severity that we are talking about, Stage IV, in order to eradicate the dead tissue and replace with fresh, et cetera, et cetera, it is a very invasive procedure. Many patients cannot withstand that, especially by that point. So they are preventable. There is no question they are preventable.

The CHAIRMAN. Thank you. Are urinary tract infections and also fractures, burns, and scalding preventable and treatable for nursing home residents?

Dr. LOCATELL. Yes, they are.

The CHAIRMAN. So these questions are not, by any means, inevitable conditions among nursing home residents?

Dr. LOCATELL. That is my belief, yes.

The CHAIRMAN. Competent staff should be able to distinguish between those cases in which failure to eat or successfully absorb food or water is unavoidable and those in which it is avoidable?

Dr. LOCATELL. They most absolutely should. If they are looking at the patients and they are using their clinical skills, their training, what they were licensed for, absolutely.

The CHAIRMAN. So just, once again, we are talking about the delivery of care, type of care that is under the control of the facility and should, if done right, prevent a majority of these conditions from occurring?

Dr. LOCATELL. Most definitely, yes, Senator.

The CHAIRMAN. There seems to be an attitude among some that nursing home patients are old and, for this reason, they just stop eating, they waste away and, because of this, there is no sort of conscience that there has to be about death. Do I understand you correctly that you are telling me, as a medical professional, that it is not that simple?

Dr. LOCATELL. Well, I think ageism underlies a lot of the poor care, especially on the part of the medical community. Yeah, they are old. It is their time to die. But, of course, it is not that simple. Primarily, these people are disabled and they need care.

The CHAIRMAN. Now I have asked you the questions I have asked you because tomorrow we will be hearing testimony implying that these conditions are unavoidable. You probably will not be able to respond to those testimonies because you have not heard it, but you are making very clear, at least as I describe it, that these are avoidable situations and, particularly, the situation that you, as a medical professional, would not accept the view that people might just stop eating and, consequently, if you stop eating, waste away—

Dr. LOCATELL. Well, you know, if you——

The WITNESS. Consequently, if you waste away, you die.

Dr. LOCATELL. Well, if you, again, I am with Trish on believing in the MDS process because it is a blue print for how to take care of patients. And one of the areas that is asked in MDS is mood, and these patients are depressed, and depression can be treated. So, no, they should not just be allowed to waste away and not receive the care that we have available.

The CHAIRMAN. Dr. Locatell, in your testimony you describe a number of situations of falsification of documentation on the part of facility staff. You make particular reference to discrepancies between information on clinical charts and information on the MDS. In fact, I think you said the MDS is accurate only about 50 percent of the time.

Dr. LOCATELL. Yes, that is what I prepared in my statement.

The CHAIRMAN. The MDS data is now required to be automatically transmitted to HCFA and Medicare payments are determined according to the patient's need as recorded on the MDS. Can you elaborate on the implications of falsification of patient data as it impacts patient care and also payment.

Dr. LOCATELL. Well, it is my understanding that the more disabilities reported on MDS, the more facility will receive in funding. I do not know of that directly, but I understand that that is part of what determines funding to the facilities, both from Medicaid and Medicare. Trish may be able to talk about that a little bit more.

As far as the care, when you look at the care plans for these patients that are developed out of the MDS process, they frequently reflect a lack of nursing understanding of what the basic process is for and why the items are located there. So you will find kind of nonsensical care plan being generated out of these faulty MDS completions. It is very prevalent in the nursing homes that I have visited, where I have scrutinized it.

The CHAIRMAN. I am going to now go to Ms. Duncan.

Ms. Duncan, among your responsibilities as an activities director you had the task of recording the assessment of a resident's activity time on the MDS. Your written testimony states that you were asked to change your assessment because it was not consistent with others. Can you explain why you were asked to change your assessment and in what way were your assessments inconsistent with others?

Ms. DUNCAN. A majority of the time when I was asked to change it was the part that reflected isolation. I think the doctor understands an isolated patient can get depressed and disassociate from other people.

Isolation is triggered by how often they go out of their room, how often they are in activities and their level of participation. Now these are things that I physically saw. OK, they never left their room and they did not participate, therefore, they are an isolation case. And in my section, I would trigger that they were in isolation, lack of participation.

Now this would have to affect, when you—God, it is hard to explain the MDS. It is a very complicated, inter-wound type of—so that when I trigger that they were isolated for activities, Social Service would have to address how they are dealing with the isolation. Nursing would have to address if this had any medical issues, psych evals would have to be—all of that flows together. So if I triggered that—and I knew this person did not go to activities. This person stayed in their room, and they were isolated, and if I wrote that down and the Nursing Department did not want to deal with that part of the MDS or they had already filled theirs out and they did not make any mention that this person never left their room, and Social Service did not mention it, and I am the only one that mentioned it, it would cause a problem. So they would have me change it.

The CHAIRMAN. For everybody down the chain, right?

Ms. DUNCAN. Everybody down the chain has to address—

The CHAIRMAN. Who asked you to change your assessment?

Ms. DUNCAN. The person in my building at those particular times that was in charge of it was the director of nurses.

The CHAIRMAN. Also, Ms. Duncan, some people would argue that Federal and State requirements for recordkeeping might be seen as busy work, which deflects the energies of staff away from patient care. However, more than once you stress the importance of accurately noting administration of fluids and meals, as well as noting important changes in eating habits and patterns. Specifically, you said that charting and evaluation by the CNA is the key to quality of care.

Can you explain your rationale of linking accurate recordkeeping to quality of care, and can you address the argument that all of this paper busy work actually contributes to poor quality care because it deflects staff energies away from direct hands-on patient care?

Ms. DUNCAN. Let me talk about the first part of your question because the second part kind of confuses me a little bit.

In regard to adequate and accurate charting, if I accurately chart how much your mother drank, and she did not drink enough, then you would know about it before it became a dehydration issue. If when I was changing her and I changed her every 2 hours in my 8-hour shift and she never had a bowel movement, and on the ADL record it noted that she had not had a bowel movement in days, then we may have a bowel impaction that the doctor would be better addressed to tell you what kind of problems that creates. But if I chart correctly and accurately, then I can alert a nurse, "Hey, look, there might be a problem here." The nurse watching the chart

would say, "Oh, yeah, there might be a problem here. Talk to the doctor."

Adequate, accurate nursing from the CNAs. If I fed somebody and they started losing their appetite, I would be the first one to know, and if I accurately write that down, that they have a loss of appetite or they are eating less, then the charts would reflect it, the nurses could do something about it, and the doctors could be called.

The CHAIRMAN. So you are making a point that very good record-keeping is very basic to the quality of care.

Now the other argument that I am asking you to address is, people who would say, well, we spend so much time on paperwork, we cannot deliver hands-on quality of care.

Ms. DUNCAN. Then you need to hire more people, so they are not so rushed. Because it is absolutely important that they have the time to accurately chart. It is absolutely important.

The CHAIRMAN. Is it at least theoretically possible that good quality care was being provided and the staff were just going through the moments of filling out the required paperwork?

Ms. DUNCAN. Clarify that just a little bit.

The CHAIRMAN. Well, in other words, that by doing this, that they were giving some care, but when it came to filling it out they actually were not giving the filling out of the paperwork the proper attention that it ought to deserve for a basis of quality of care.

Ms. DUNCAN. I believe that, theoretically—well, I think that it is possible that they did do the care, and they did it well, but they did not accurately chart it, you still have a problem. Any way you cut it, you have to put down accurately in your charts what you are doing, good or bad.

If I did not get a chance to shower, that should also be on there. I should also say I did not have a chance to shower this patient, and I should chart that, I should not feel like I have to chart on there that I did shower because I may lose my job.

The CHAIRMAN. I would continue with you and Ms. Lloyd on another question. In addition to the charting practices of CNAs, you also cited occasions in which other facility staff, including supervisors, corrected and filled in information in the patient's medical records. Are we talking about a widespread practice of altering patient information?

Ms. DUNCAN. In the five buildings that I worked in, yes, sir, on all levels.

The CHAIRMAN. Ms. Lloyd. I see Florence shaking her head. Do you have a comment on that?

FLORENCE N. Sometimes I do not even consider the charting because I know that it has been altered. I know it is inaccurate, and I just disregard it. The MDS is supposed to reflect the current status of the patient, and I can go look at an MDS and go look at the patient, and they do not match. So I know that things have been altered. I have given many citations, and I have seen many patients where the records have been altered. The care plans have been backdated. It is an ongoing problem, and I can verify what the other two have said.

The CHAIRMAN. I noticed all three of our other witnesses were nodding affirmatively to what Florence just told us.

Now for Ms. Lloyd. You were an MDS coordinator for your facility. We have heard from other witnesses that there is some falsification of records and documents in facilities. On the basis of your own experience, how would you characterize the reliability of MDS information? Can it be trusted or is it unreliable?

Ms. LLOYD. It is unreliable.

The CHAIRMAN. Ms. Duncan, you spoke of the nursing homes knowing ahead of time when survey and certification teams would be coming. In your experience, was facility management usually correct in their assumption as to when a survey team would arrive?

Ms. DUNCAN. Usually within a week to 10 days they could pretty accurately assess when they were coming, and for those 2 weeks prior then you just had extra staff.

The CHAIRMAN. Do you know how the facility staff learned about how the surveyors schedule?

Ms. DUNCAN. Not firsthand, no, sir.

The CHAIRMAN. And did facility staff do things differently when they were expecting survey and certification teams? For instance, did they add staff and, if so, where did those staff come from?

Ms. DUNCAN. Yes, they added staff. We would often schedule for overtime, bring in part-time people in all departments, all departments; housekeeping, maintenance, activities, and nursing. They would bring them in. Now, on the nursing, they would sometimes recruit from other buildings within that corporation. I was recruited on two separate occasions to go from one company-owned building that was not expecting survey to work for 4 or 5 days at a building that was expecting survey.

The CHAIRMAN. Ms. Lloyd, I should go back. You answered affirmatively that the MDS is unreliable, but would you explain and elaborate on the unreliability of MDS.

Ms. LLOYD. The MDS is the assessment tool that the nurse has. In the first 14 days, when you assess a resident when they come in, you are relying on the data that is collected in the chart. So on day shift, night shift, and P.M. shift, you are relying on certified nursing assistants to document everything this resident is doing. They are putting that in the chart, and then the assessment coordinator is going back, reviewing all of this information, and compiling all of the data to come up with a plan of care.

When you are done with all of this information, if all of it is inaccurate, then you come up with a plan of care that is inaccurate, and then the patient fails.

The CHAIRMAN. Thank you for your elaboration.

Ms. Lloyd, you stated that you were aware that the administration in one facility where you worked had brought in industry consultants to assist in presurvey preparation. I would like to have you elaborate on that. How often did it happen, as far as you know, and do you know how common this might be in the industry?

Ms. LLOYD. I, personally, believe that the MDS, a lot of people do not know how to do the MDS. They are not trained in the MDS process, so you have to get consultants from outside of your own facility to train your personnel inside the hospitals on how to do the assessment. It is all dates, unfortunately. Their dates—it is a compliance thing, and as long as the dates are in place, then DHS does not question anything. As long as you have the dates where

they are supposed to be, DHS just really does not pay attention to it.

So when the industry consultants came in, that is basically what they taught us. That was the most important thing was the dating of the MDS's and making sure we are dating them appropriately. They went through the entire hospital, pulled every MDS and every chart, 120 beds, and put brand new MDS's in there and made up the information, just so we would comply because we were like in fast track.

We had so many complaints about this facility that we had to clean it up before DHS came back. Because when they come and they fine you or they give you a bad report, then you have to clean up your act within so many days because you know they are coming back.

The CHAIRMAN. Florence, I would like to follow up with you on a question previously asked. We have heard several times from individuals that nursing homes often know ahead of time when a survey team is to arrive. How exactly does this happen if the policy states that the survey visits are to be unannounced? Do you know of any cases in which nursing home facilities were informed in advance by surveyors, or other state personnel of an inspection or is it simply a matter of predictability?

FLORENCE N. They are not informed in advance, but they can figure it out because within 12 to 15 months we are going to be there, and they are pretty smart. They keep track of where we were last, and they know, more or less, within 12 to 15 months we are going to come. So most of the time they can predict that we are going to be there within a month, at the most, within 2 weeks to a month we will be there. They know when we are coming.

The CHAIRMAN. So it is a matter of predictability and not somebody calling up and saying, you know, you are the next one to be inspected.

FLORENCE N. Right. We never, as far as I know, no one ever tells them, but they do figure it out, and they do bring reinforcements from the corporation, from registries. The first day if you want to find things, the best way to catch them is the first day. You look at the residents, how they are fed, and how they look because the second day by then they have their reinforcements and staff all over the place, and the linen is supplemented, and they have reinforcements. I call them reinforcements. But the very first day that you come, that is when you see the most problems.

The CHAIRMAN. Your testimony got right at the heart of some of the very serious problems we have about whether or not surveys and enforcement are working. One of them you mentioned about the defeating nature of the surveyor's job. You used the word "complacent" to describe the attitude that some surveyors develop. You also said that some just seem to give up.

What is it about the job that is so defeating and what can be done to correct this?

FLORENCE N. We are trained to enforce the regulations that were developed. It took HCFA 12 or 15 years to develop this litany of regulations that is supposed to be beneficial for the patient. When we try to enforce them, we are either told by the upper echelons to back off or we are given some excuse.

Sometimes the providers complain about the surveyors, and you are pulled away from that facility. Some providers or their attorneys complain about you, and then you are not allowed to go there. If you get too rigorous and you try to enforce the regulations, they will complain about you, and then you will be kept away from that facility.

There are many providers that do not want certain surveyors in their facility simply because they know that they are going to enforce the regulations. Sometimes after we do try, we are defeated because the upper administrative people overturn our decisions. So then you do kind of feel like, "What is the use? All of my efforts were for naught," and the families feel that there is no justification, there is no justice. They know that their relative or their loved one was harmed. They know something was wrong, and then there is no penalty for the providers. They just go on and do business as usual.

When you are reprimanded for being too rigorous, what happens is that you feel that, "What is the use?", so sometimes you just give up. There is no sense trying to correct the thing if somebody is going to negate your work after you go and do that. It gets kind of disillusioning to try and do your work.

The CHAIRMAN. Let me follow up, and then I am going to turn to Senator Breaux. You just referred to upper-echelon people in your comments. Do you mean management? Who are these people and, more importantly, what is their motive for taking no action?

FLORENCE N. I am talking about the high administrative appointees by the Governor who are running our department. They have no medical background. They are appointed officials, but they run and make all of the determinations, and there are political ties. The providers go and meet with them, they complain about the surveyors, they say that we are not letting them do their business, and so then we are told to back off because the providers are complaining about us.

So some surveyors do kind of give up, and they just kind of get complacent, and they do not enforce the regs and nothing gets done. The patient is the one that suffers.

The CHAIRMAN. Senator Breaux.

Senator BREAUX. Thank you very much for your testimony.

I was just wondering, this is all extremely depressing. Have any of you ever run across any good nursing homes?

Dr. LOCATELL. Yes.

Senator BREAUX. I say that in all sincerity. I mean, this is a major indictment of one state's nursing homes. Doctor, can you kind of, just for the sake of my brief questioning, move a little bit so I can see.

How many nursing homes do you all have in California, any idea?

Dr. LOCATELL. 1,500–1,400.

Senator BREAUX. If you had to because of your experience sort of quantify good, bad, and the ugly, how many of each? Are all of them like this or is just one third of them like this, half of them are like this? Are there no good nursing homes in California?

Dr. LOCATELL. When I read the GAO report and I saw that only 2 percent had minimal or no deficiencies, does that answer your question?

Senator BREAUX. Two percent?

Dr. LOCATELL. Two percent.

Senator BREAUX. Two percent minimum or no deficiencies.

Dr. LOCATELL. Two percent. Now they categorized the deficiencies. A third of them were the ones that were the most likely to cause bodily harm, a third were less serious but could lead to harm, and a third were kind of minor, but, you know. It was divided up about that way. Only 2 percent had minimal or no deficiencies.

Senator BREAUX. If I was thinking about putting a parent or a loved one in a nursing home in California and I did not know where to go to find out which ones would be the good ones and which ones would be the ones I would not want to use, where would I go to find out that information or can I find that information on the facts that are available today?

Dr. LOCATELL. In California, the information about citations is readily available. It is actually available on the Internet. It is also available from the Department of Health Services. So, No. 1, you can get your history of citations. As Florence pointed out, though, it does not necessarily mean anything, but at least you can find out this one, this particular one, has had ten Class A citations in the last 2 years.

Senator BREAUX. So in California, at least, the information on citations for violations charged by the State is on the Internet. Now what is on the Internet, a fine, or a citation or what would it be? Because I noticed in Louisiana they said that there was something like only 11 percent of those inspected or whatever or found to be in violation were actually fined.

Dr. LOCATELL. Yes.

Senator BREAUX. So is the information credible information? It is on the Internet, which is good. Is it credible information?

Dr. LOCATELL. Actually, yes, because the source of the information is actually a nursing home reform advocacy group. California Advocacy for Nursing Home Reform maintains this on their Web site, all of the information about citations and fines.

Senator BREAUX. Let me explore this a little bit further. Is this a way to ensure that people will pick the ones that are good and not go to the ones that are bad, thereby getting them out of the business because of lack of use or does it make any difference at all? With all of this information, are people still going to the bad nursing homes?

Dr. LOCATELL. Well, the problem is usually the family member ends up in the nursing home at a time of crisis. Hey, you need to get out of the hospital. Here is where there is a bed, and that is where you go, and you can go and look it up all you want, but you have got to get out of the hospital today because, boom, you do not need to be here any more. That is how a lot of residents end up in these substandard places, and then they stay there. They never get rehabilitated, and they stay there for long-term care.

When there is a choice, and a planning, and a chance to go and look around, that is the exception, I think, and that is one of the

reasons the public gets so frustrated about having to choose a nursing home because they are just forced into it in the middle of a crisis.

Senator BREAUX. So the publication and making available of information on the good ones and the bad ones is not, in your opinion, enough to be able to have a major influence on those that are bad because people make the decisions in a time of crisis.

Dr. LOCATELL. That is correct, yes.

Senator BREAUX. Now I have been looking over the minimum data set, and this thing is quite as confusing to me. I mean, there are pages and pages of such small fine print, and it covers just about everything; communications, hearing patterns, cognitive patterns, mood and behavioral patterns, and under each one of these is all kinds of boxes to check.

I just this weekend filled out one of these things on an air conditioner that I bought, and the only way I could get the warranty is if I filled out what made me buy it, and what did I think about it, and all of these questions. It became so frustrating I just checked of all the things, OK, OK, OK, OK, OK, because I did not want to spend all of the time doing it.

The point is that it seems to me that the people who fill out this are the people who are running the shop. It is like me being given a survey on what kind of job is Senator Breaux doing as a Senator. Does he come to hearings or does he ask good questions? Does he offer good amendments? Does he dress right? I would just check OK, OK, OK, OK or excellent, excellent, excellent in all of the categories, and I would submit it and somebody would get this. I do not know what they would do with it. But they would get it and say, "Goll, he is terrific."

Is it the fox in charge of the chickens? You are saying, I guess, Ms. Lloyd, you are saying the people in the place fill out the forms and sometimes they do not fill them out correctly. I mean, how do we solve this? Do I have a Federal inspector or a State inspector in every nursing home filling out the forms? Is it correct that, basically, the people filling out these forms are the people that either work in the nursing home facility or own the nursing home facility?

Ms. LLOYD. I think you just need to staff the place.

Senator BREAUX. I am sorry?

Ms. LLOYD. They need adequate staffing.

Dr. LOCATELL. Kathleen's point is absolutely correct. This charting is critical to know what is wrong with the patient and what to do for the patient, for the resident. Her point was the main reason why this MDS tool is so important and why the charting, the false charting, is so devastating, and it all goes back to staffing.

Senator BREAUX. I do not know what HCFA does with this MDS information. I think they are trying to address it in their proposals, but does all of this come to Washington and someone with a green eyeshade reads each one of these? Is that the idea?

Dr. LOCATELL. There was a recent journal, The American Geriatric Society, that the entire journal was devoted analysis of MDS data, and I read it, and I just shook my head, and I had to throw it aside because it had no basis in reality. People are studying it. They are accumulating this data for some reason, but it is not

being used to provide appropriate care plans for residents, and it is not being filled out correctly.

Senator BREAUX. Both of those two things are a real indictment of the process. Now we are going to hear from industry tomorrow. We are going to hear from HCFA. We are going to hear from nursing home associations to hear their side, I guess, of what their perspective is on where we are. But if the information is inaccurately filled out, it is not worth the paper it is written on. In fact, it is worse because it is giving us wrong information on which to judge the competency of a facility. That is really very, very bad if that, in fact, is what is happening.

Senator Grassley made a point. Are we spending too much time on information? It is an incredible amount of detail work that we are requiring. Maybe it is the right thing to do, but we are talking about a shortage in having somebody to turn mom or dad over in the bed so they do not get bed sores or filling out oodles of paperwork, I would rather have them doing the former.

Dr. LOCATELL. Well, like most government forms, it certainly could be more user friendly.

Senator BREAUX. It gives you a headache just reading it, let alone filling it out. There has got to be a better way, and that is the bottom line. So I appreciate it.

Ms. Lloyd, are the facilities that you talked about filling out forms inaccurately still in business?

Ms. LLOYD. Absolutely.

Senator BREAUX. Absolutely they are.

Ms. LLOYD. I have been to the U.S. District Attorney in California. They do not care. I mean, I have been forward. I have said exactly what goes on, and it does not matter. That is why I am here.

Senator BREAUX. Really? What do they tell you? I mean, when you bring——

Ms. LLOYD. We will investigate, just like you are saying. So I am hoping something comes of it. Could I add something?

Senator BREAUX. Sure.

Ms. LLOYD. That MDS is complicated to you because you do not understand it. It is so critical, and it does work.

Senator BREAUX. You think it is important.

Ms. LLOYD. A team of experts got together to make that form. That will help you take care of a resident, and you will not get "decubes," and you will feed that person. You will maintain their psychosocial well-being. That thing is critical, and it works.

Senator BREAUX. If it is filled out correctly.

Ms. LLOYD. Absolutely.

The CHAIRMAN. Do you agree with the doctor that it could be simplified and still be valuable?

Ms. LLOYD. I think it works. I do not think—I think people need to be trained. You cannot, you know, these people that form is foreign to them. When you implemented this, you forgot to train everybody on how to do it. Then you said you have got to have it computerized. So they have not even quite figured out how to fill them out, and now they have to put them on computer, so that we can send them to the government to let you know something. We do not know what it is.

The CHAIRMAN. Well, they are the basis for the Prospective Payment System, which the industry has asked for, they want to be paid for based upon these reports. That is why it has got to be very accurate from the standpoint of the taxpayers' money being spent wisely as well.

Ms. LLOYD. But you know what, the thing is, is that we are misleading you because we are telling you everyone that is in this nursing home has some serious cognitive or physical ability problem, and that is not accurate. So you are paying us to take care of these people, and they do not belong there.

Senator BREAUX. Let me ask just a final question. You folks are in the field. You are right in the middle of it all, and we are sitting up here trying to figure out how to make it better.

If you were sitting up here, what would you recommend that we do to try and address what you have described as a very serious problem?

Ms. LLOYD. Take away their money. Take away their money, and then—

Senator BREAUX. Yes, but that may close the nursing home and where does grandma go?

Ms. LLOYD. Absolutely not. You hurt these people, I honestly believe, and I am so anti-litigation, and I believe in suing these people. I believe the minute you take away their money, then they are going to start getting worried. They are going to take care of grandma because, see, grandma cannot talk. Grandma cannot vote. Grandma has no money, so no one cares about grandma and grandpa. You would never get away with this in acute care with a 40-year-old man. But you are talking about these elderly little women.

If you start hurting these owners and take away their money, they are going to stop it. The insurance companies are going to start looking and saying, "We are sick of paying out all of these millions of dollars. You better start doing your job," and it is a trickle down. So it does work.

Also, I believe with the survey process you need to go in there that first 24 hours and do not leave because the minute you walk out that door, they are going to staff the whole hospital, and I am telling you I was part of administration, and we do that. That is the way it works. I will rewrite a whole chart if I have to with my director of nursing and the owner. Do not leave. Your first 24 hours, check the whole place out and do not leave.

Senator BREAUX. Ms. Duncan, what is your suggestion?

Ms. DUNCAN. Two, one thing I would like to address, as far as the MDS. The MDS, CNAs do not generally touch it. They do not do the charting, but the nurses read what the CNAs have written down, and charting in my training was so tiny. It was so very little emphasis. In my group of CNAs, 20 percent English was not their first language. Most of these forms are all written out. The training was done in a language that was foreign to them, and it was very difficult for them to understand what was expected of them.

When I went to the college and took the courses for the activities director, charting was one day, and that was for all of the charting. That was for your progress notes, your quarterly notes, basic assessments, and your MDS's. It was all crammed into one day. It

is impossible. They do not understand what has been expected of them. They are not trained to know what has been expected of them.

Yet, what a CNA, who may not actually have even understood the question because this is not their mother language, is filling something out that she is going to be reading to make the MDS.

I am going to tell you a story, just a little one, because it is kind of quirky. In one building I was in, in Petaluma, we had INS show up one day. Fifty percent of our floor disappeared. I was in management at that time. Do you know what I did that afternoon? I fed patients, and when I was done feeding them, there was no one in the kitchen, so I washed dishes for 4 hours because our staff left.

I am trying to tell you your problems go even deeper than just filling out this paperwork. They have to know what is on this paperwork, what is expected of them. Am I making a point?

Senator BREAUX. Thank you very much.

Doctor, what would your recommendation be?

Dr. LOCATELL. Well, we need enforcement of the laws that we have. We need surprise inspections. We need inspections after hours. We need no grace period. We need no second chances for some of these facilities that are just repeat, repeat, repeat offenders. We already have the backbone of the regulatory system in place. We just need to make it work.

Senator BREAUX. Is there a comparison between an acute care facility, a hospital, and a nursing home as far as how these regulations are enforced?

Dr. LOCATELL. Well, in an acute care facility, of course, they know when their inspections are coming too. So you make a very good point.

One of the big differences in long-term care is there is no one there who is actually advocating for the residents. In the hospital, it is a little bit different.

Senator BREAUX. Ms. Florence, as an inspector for the State, how would you recommend or what would you recommend that would allow your department to do a better job in making sure that the nursing homes do a better job?

FLORENCE N. The first thing I would recommend is that the nursing home industry invest some of their profits back into the facility, into training their staff. Like I said before, the CNAs have very poor training. They are not able to document accurately because they do not understand the forms.

The MDS that everybody is discussing is a very good tool, and it can be very well used if it is done appropriately. It is supposed to reflect the current status of the residents. It also allows you to do another assessment when there is a change. So the nurses that are filling out these MDS's have to know how to use the tools. They have these specific RAPS that describe problems. They are very informative, and if you follow the process, you can do a good job.

But the nursing homes do not pay the staff enough. They do not have the time or the personnel to do a proper job. I think the whole issue revolves on greediness from the nursing home owners, the providers. The administrators drive these big fancy cars, while the patients are walking around with tattered clothes. They do not get fed. In some cases, they do not provide enough food. They run them

as cheaply as possible, and it is at our expense. We are the taxpayers, and our money is not being put to good use.

I think the elderly deserve better. They have worked hard. Some of them are very prominent people, and they did not go there to die. They did not go there to be neglected, to be left in their feces or their urine. Some are soaked up to their waist when their diapers are wet. They walk around drooling with mismatched socks, sometimes no shoes, sometimes they are restrained. They are never repositioned. It is kind of atrocious. It is a crime.

But if you are too rigorous, like I said, the administrators will complain about you, specifically, and then you will get pulled away from that facility. So you kind of have to do your best and just hope that somehow you can influence just by being diligent.

The MDS itself is a good tool, and I think if they would pay somebody and train them appropriately, the tool would work. It looks confusing. But once you learn how to use it, it is easy, and you can use it to compare, every 3 months. A yearly MDS is the most comprehensive, and that is that long form eight pages long. But the quarterly MDS are very simple, and it is just a good comparison. It is a useful tool.

Senator BREAUX. Let me thank all of you. I think you all have been very, very helpful. You have given us inside information about a perspective that is very important for the Congress and the country to hear about. And, Florence, do not give up.

FLORENCE N. I will try not to.

Senator BREAUX. Thank you all very much. Thank you, Mr. Chairman. Good hearing.

The CHAIRMAN. I have two questions of Florence, and then I will have Florence depart, and the cameras will have to be off while that happens.

You noted that there are, from time to time, interventions in the decisions made at the Citation Review Conferences which have reversed the results of the hearing officer's decision. Would you tell us more about that, but most importantly, who is it that is doing the intervening?

FLORENCE N. Well, sometimes the physicians involved have friends in those facilities and they intervene. Sometimes it is the provider's representative that intervenes. Sometimes it is the administrators and the owners of the nursing homes themselves. They come, and they negotiate with our department, and the penalties are reduced. The severities are reduced, and there is not too much you can do. Once upper-management makes the determination, it is too bad for you. Your citations are reduced, and there is not too much you can do.

The CHAIRMAN. Do you think that the Federal citation classification system, and I am referring to the scope and severity grid, and the systems used by California accurately classify the types of violations occurring in nursing homes?

FLORENCE N. Well, I know, for my part, we try to scope and give them the right severity. Sometimes our supervisors and administrators reduce that scope and severity, and you may not agree with that, but that is what they do. They make the final determinations, and that is why I am saying that the people that have the medical

knowledge do not end up making the final determinations, and that is a problem.

The CHAIRMAN. Could I summarize what you just said by saying that there are certain violations that would currently draw minimum penalties when, in reality, they are really serious enough to draw more serious penalties?

FLORENCE N. That is correct.

The CHAIRMAN. Do you have suggestions on how it might be improved, and I do not want a technical answer, just kind of in your own words some ways that this could be improved?

I can leave it this way, if you have a hard time responding to that.

FLORENCE N. I have a hard time.

The CHAIRMAN. Could you respond in writing to my staff or they can telephone you and get an answer that we would put in the record?

FLORENCE N. Yes, that would be better for me. I would recommend that very specific terms and terminology be used to determine the resident outcome, so that there is an absolute and consistent measurement of the harm or potential harm to the resident. At present, there is a lot of room for individual interpretations of terms and terminology so the remedies imposed depend on who is doing the interpreting and enforcing the penalty.

The CHAIRMAN. I would ask the television cameras to be off, and we would like to have Florence be safely out of here before I—I am about ready to close the meeting. I have just maybe 60 seconds of closing comments for today. And, Senator Breaux, you can too.

I would like to talk about a procedural thing, tomorrow's hearing, and this is something we are going to have to communicate to our members as well. Because of the tragedy on Friday the Senate will be taking a 45-minute period of silence from 11:45 to 12:30 tomorrow, and that may, for sure, interrupt some of our hearing. So we are going to stop for that period of time for that.

Then, if we are not done by 2:45, there will be a period of 2:45 to 3:30 in which there will be a service for the victims of this tragic incident Friday. I think out of respect for what the officers do, not just to make the process of government work, but for the visiting public, we need to do that, and I am going to do that. So, accordingly, we will just have to play tomorrow somewhat by ear, but we will still start on schedule.

I think that Senator Breaux, probably, in his opening question on the last round kind of spoke in my train of thought that this was not a very good news day. I suspect it was the same for many of you who are in the audience because what we heard is what we thought we had ended almost a decade ago with the 1987 Act after all of the reports of the Institute of Medicine. I keep referring to the San Jose Mercury newspaper article and other General Accounting Office reports. But, unfortunately, it looks like we have been proved wrong.

I also have to say thank you to each of our witnesses, including the three that are still at the table. I cannot imagine how difficult it was for you to revisit the situations that I am sure you would rather forget. This committee and the State of California owe you

all a debt of gratitude. You put yourselves on the line for greater good, and I applaud you for doing that.

I would like to point a few tips that I hope will be helpful. These are a few things that the public may want to consider before they place a loved one into a nursing home. It seems to me one should investigate by evaluating the state's survey of inspection. Each state conducts inspections at least once a year and issues reports of its findings that have to be available to the public. It is required to be readily available at all nursing homes: Also make unannounced visits to prospective nursing homes. Use your senses. Look, listen, smell, walk through the hallways, speak to residents, visitors, most importantly, the nursing home staff. Get a sense of the environment.

I would also point out a few tips that may be helpful when loved ones are already being cared for in a nursing home. Most importantly, I think, we saw from the first panel, even if you are greatly involved, it is not necessarily an ideal situation for your loved ones there, but just think how much more tragic it would be if you were not involved. Your involvement will, I think, make quite a difference, and particularly living nearby, visit frequently. Residents whose families visit regularly tend to receive better care than those who do not have visitors. If you do not live nearby, think about appointing a representative who could go in your place from time to time.

Another tip would be to monitor the facility's quality performance. Periodically request copies of all incident/accident reports from the nursing home. Ask to see the survey findings in the most recent inspection. Ask the director of nursing or administrator questions about deficiencies if you would like to know more. Talk to an ombudsman. Get to know the family members of other residents who visit the facility and subscribe to the facility's newsletter if there is one.

I thank you all very much, not only the witnesses, but the public who has been here. Thank you very much and, most particularly, to my colleague, Senator Breaux.

Senator BREAUX. I would just make a brief follow-up to what you said. I think the hints are very, very important. I think that the more information a person can have about where they are sending a patient, the better off they will be.

It seems to me that people get more information when they buy a used car in America than they do in selecting a nursing home. Maybe that is not true, but I tend to think that they do a lot more shopping when they are looking around for a used car. And maybe, as you said, Doctor, that it is because of the emergency nature of the situation.

So I think that that information is critically important, so people can make wise choices, and those wise choices would make a major contribution to upgrading the quality of all of the facilities that are selling the services.

But I think all of you have been very, very helpful, and I look forward to tomorrow's testimony because we will have witnesses who represent the nursing homes. So I think it ought to be very interesting to see what kind of hearings we have tomorrow, and I thank the chair for setting it up.

The CHAIRMAN. Senator Breaux, you do not have to respond to this now, but I wonder if, because of Dr. Locatell's situation there with the University of California, if we should not talk to Senators Feinstein and Boxer and see if we can, all together, look into her situation and see the extent to which she has been unfairly treated.

I will just adjourn with that. Thank you all very much.

[Whereupon, at 4:36 p.m., the committee was adjourned.]

BETRAYAL: THE QUALITY OF CARE IN CALIFORNIA NURSING HOMES

TUESDAY, JULY 28, 1998

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Washington, DC.

The committee met, pursuant to notice, at 10:17 a.m., in room SH–216, Hart Senate Office Building, Hon. Charles E. Grassley, (chairman of the committee) presiding.

Present: Senators Grassley, Collins, Breaux, Moseley-Braun, Reid, and Reed.

OPENING STATEMENT OF SENATOR CHARLES GRASSLEY, CHAIRMAN

The CHAIRMAN. I am Senator Chuck Grassley, chairman of the Aging Committee. I would like to call our meeting to order and say that the attendance is what it is right at this minute because we are voting. But I did not want to wait until the vote closed to start because I think that we are going to have a very tight schedule and maybe longer day than we anticipated, and that is because of the tragedy that happened on Capitol Hill last Friday.

The Senate, including this Senator, will recess the meeting at about 11:45 to join our colleagues in our moments of silence that will take place in the Rotunda from 12 until 12:15. Then I plan to reconvene the meeting at 12:30, and finish then, hopefully to be done by the time that we have another recess for the services this afternoon from 2:45 to 3:30. But regardless of whether we get done at 2:45 or not, I intend to complete this hearing today because I think it is so important that we get all this testimony on the record prior to our August summer break.

So I want to welcome all of you to day two of our hearings entitled "Betrayal: The Quality of Care in California Nursing Homes." Yesterday, we devoted the day to horrifying and painful stories of several victims regarding their experiences in California nursing homes. We also heard from several insiders within the California nursing home community. These insiders described to us what they had personally seen, heard, and done while working in California nursing homes.

After listening to yesterday's witnesses, some may believe that these witnesses were simply describing isolated incidents that happened over the years in California nursing homes. After all, we all do make mistakes. Nothing, of course, can be further from the truth, and today you will find out that we are not describing an isolated problem or two. We are not speaking about a nursing home

resident or two. We are not describing a mistake or two. We are talking about a systemic problem in California nursing homes, where more than 140,000 of our vulnerable and defenseless citizens spend what are often their last days.

Today's hearing will be divided into three panels. First, we will hear an overview of the infrastructure that was created by the Federal Government to ensure that nursing home residents receive adequate care. Immediately thereafter, we will hear from the GAO. That agency will tell us about their findings. In my opinion, these findings are the equivalent of a national scandal.

We will hear also from a nationally renowned researcher in the field of long-term care. She has provided many, many recommendations to the Health Care Financing Administration over the years. HCFA is the agency that pays nursing homes with our Medicare dollars. HCFA is also ultimately responsible for ensuring that nursing home residents receive adequate care. Finally, we will hear from HCFA and industry representatives.

In addition, we extended an invitation to the State of California to appear before us today. We extended this invitation because the committee thought it was important to provide California with an opportunity to respond to both the GAO findings and yesterday's witnesses. We were also hopeful that the State would set forth a plan to address the GAO findings. Unfortunately, the State of California declined my invitation.

[The prepared statement of Senator Grassley follows:]

PREPARED STATEMENT OF SENATOR CHARLES GRASSLEY

Good morning and welcome to Day 2 of our hearing entitled "Betrayal: The Quality of Care in California Nursing Homes." Yesterday we devoted the day to listening to the horrifying and painful stories of several victims regarding their experiences in California nursing homes. We also heard from several insiders within the California nursing home community. These insiders described to us what they had personally seen, heard and done while working in California nursing homes.

After listening to yesterday's witnesses, some may believe that these witnesses were simply describing isolated incidents that happened over the years in California nursing homes. After all, we all know mistakes happen. Nothing could be further from the truth. Today we are not describing an isolated problem or two. We are not speaking about a nursing home resident or two. We are not describing a mistake or two. We are talking about a systemic problem in California nursing homes where more than 140,000 of our most vulnerable and defenseless citizens spend what are very often their last days.

Today's hearing will be divided into three panels. First, we will hear an overview of the infrastructure that was created by the federal government to ensure that nursing home residents receive adequate care. Immediately thereafter, we will hear from the General Accounting Office. The GAO will tell us about their findings. In my opinion, these findings are the equivalent of a national scandal. We will also hear from a nationally-renowned researcher in the field of long term care. She has provided many, many recommendations to the Health Care Financing Administration (HCFA) over the years. HCFA is the agency that pays nursing homes with our Medicare dollars. HCFA is also ultimately responsible for ensuring that nursing home residents receive adequate care. Finally, we will hear from HCFA and from industry representatives.

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I will now turn to Senator Collins.

STATEMENT OF SENATOR SUSAN COLLINS

Senator COLLINS. Thank you very much, Mr. Chairman. I want to commend you for calling these series of hearings to examine the truly shocking revelation that residents of some California nursing homes are suffering and even dying from malnutrition, dehydration, and other serious conditions for which they are not receiving appropriate or even adequate care.

Nursing homes are playing an increasingly important role in our health care system. It has been estimated that 43 percent of Americans who passed their 65th birthday in 1990 would use a nursing home at some point in their lives. These numbers will only increase as the rising tide of baby-boomers turn into grandparents and great grandparents as we live longer and longer. This will put even greater pressure on our long-term care system.

The decision to place a parent, spouse, or other loved one in a nursing home is an agonizing one for any family. Even if the family is able to come to peace with this difficult decision, the nagging fear that their loved one might not get the care that they need, or may even be subjected to abuse or neglect, haunts families everywhere. This is particularly true when the loved one is being cared for in a nursing home that is hundreds, or even thousands, of miles away from the rest of the family, and there is no one around to keep a loving eye on the patient or to intervene on their behalf.

What is particularly alarming about this General Accounting Office report is that many of us were under the impression that Congress had addressed, and indeed solved these problems with the enactment of the Nursing Home Reform Act of 1987. Based on the recommendations of the landmark Institute of Medicine study, the underlying intent of this law is strong and clear that residents in nursing homes receiving Federal Medicare or Medicaid dollars should be treated with care and respect, and protected from harm and neglect.

The law was intended to provide a framework through which facilities could help each resident reach his or her highest possible physical, mental and general well-being. It also turned critical oversight and enforcement authority over to the Federal Government. Tragically, however, it appears that the Federal Government has fallen far short of the mark. Judging from yesterday's and today's testimony, it appears that the administration of the law by the Health Care Financing Administration has failed miserably in its basic mission to protect nursing home patients from harm and neglect.

The GAO has found that nearly 1 in 3 California nursing homes has been cited by State inspectors for serious or potentially life-threatening care problems. Moreover, the GAO reported that even when State inspectors uncovered serious problems, the Federal Government generally took a very lenient stance toward many of the homes. And while the GAO's report focuses on nursing homes in California, it concludes—very troubling to all of us—that the problems identified are indicative of systemic survey and enforcement weaknesses and that they probably exist across the Nation.

All of this is particularly troubling at a time when the administration is proposing to vastly expand HCFA's regulatory role over private health insurance. We need to seriously consider whether

such an expansion of HCFA's regulatory role is desirable at a time when it is failing so miserably in its current and primary responsibilities under Medicare.

Mr. Chairman, these are critically important issues for our Nation, for this committee, and for our elderly citizens. Once again, I commend you for your leadership in calling these hearings.

Thank you.

The CHAIRMAN. Thank you very much, Senator Collins.

Before I call on Senator Breaux, I want to give some assurance to today's witnesses because there was an effort to intimidate a witness yesterday. It is directed more, what I am going to say, to our witnesses yesterday and the people that write such letters, but it is equally applicable to each of you testifying today.

Yesterday, one of our witnesses received a letter from a large law firm. That law firm stated that the witness' planned Senate testimony exposed her to various forms of liability. I want to assure our witnesses that those statements that were made to the committee yesterday are protected and they are immune from any liability for statements made during the hearing. I am not a lawyer, but all you have to do is have a constitutional law course in a political science department and you learn what is basic about testifying before Congress. So I hope that that law firm would hire some new lawyers.

Senator Breaux.

STATEMENT OF SENATOR JOHN BREAUX

Senator BREAUX. Thank you very much, and thanks for continuing these very important hearings. I just want to make a quick point. One of the things yesterday—it seemed as if many of the people who were testifying were talking in terms of inadequate training that the workers in the various nursing homes had received and that many of them, if not the large percentage of them, were, in fact, working at the lowest level. They were minimum-wage employees that had not been properly trained in the areas that they were called upon to exercise authority, and that was pointed to as some of the problem.

We will explore that with many of the witnesses who are today. It is important that we have representatives from the industry to come in and comment on the GAO study and the audit that was done on the industry to find out what their response to those very serious statements is and have them say so on the record.

My own State of Louisiana—I just noted yesterday there was an article in the New Orleans paper that talked about the health workers being in short supply. The deficit is critical, the shortage is critical in 17 separate fields. Louisiana has a critical shortage of nurses, therapists, and other health care workers, according to a statewide study. There are over 2,000 vacancies in some 31 specialties throughout our State.

I think this article points out—and I am sure it is not just in my State, but in many, many States—that there is getting to be a very critical shortage of health care workers. If you don't have good workers—we can pass all the rules and all the regulations here in Washington, but if we don't have the people to be able to carry those rules and regulations out, the job will never get done. This

is an aspect that I want to explore today with some of the folks that will be testifying.

Thank you, Mr. Chairman.

[The prepared statement of Senator Breaux follows:]

PREPARED STATEMENT OF SENATOR JOHN BREAUX

Mr. Chairman, I commend you for taking the lead on this important issue and calling for these two days of hearings. Of the wide range of issues that we have studied in this Committee—preserving Social Security, strengthening Medicare, protecting consumers against fraud, to name a few—none are more important than protecting the welfare of our most vulnerable citizens.

I join you in making it clear to nursing home residents and employees, to policymakers in state and federal government, and all Americans, that this indeed is an important issue, one that deserves a close examination. Our goal, Mr. Chairman, must be to find solutions to the problems we will hear about today—and find them quickly.

Yesterday, we heard testimony from those who have been victimized by an ineffective system. Several of our witnesses traveled great distances to tell their stories, and I commend them for their efforts and thank them for sharing their testimonies.

Chairman Grassley, I strongly feel that security for seniors is more than just the financial security of their health care programs. Their personal security must also be guaranteed. People should be confident that if their mother or father is in a nursing home they are getting the quality care they deserve.

Today, the General Accounting Office, which did a study for the Chairman and me, will report that the current nursing home inspection process may not be doing what it was intended to do: protect residents against harm and neglect. Particularly troublesome is that in some cases state surveyors missed problems that affected the safety and health of nursing home residents, and that even when such problems were identified, enforcement actions did not necessarily ensure that the problems were corrected and did not recur. Any oversight system that lets that happen must be fixed.

I also look forward to hearing from the Health Care Financing Administration and industry representatives to hear about what they are doing now to ensure that nursing homes provide quality care. Mr. Chairman, I look forward to working with you, the Administration, resident advocates, and representatives of the industry to ensure that we never have to have a hearing of this kind again.

The CHAIRMAN. I now go to our first witness. I am glad that Dr. Charlene Harrington is coming. She is a professor in the Department of Social and Behavioral Sciences, University of California, San Francisco. Dr. Harrington is a sociologist and a nurse, and has been involved in research on nursing home quality since 1975. Dr. Harrington has published extensively.

The Health Care Financing Administration on several occasions, has contracted with Dr. Harrington to develop, design, and even implement studies on its behalf. She is here to give us an overview of the infrastructure created to protect nursing home residents, and she will also be willing to serve on our next panel to answer questions and to interact with other panelists.

Dr. Harrington.

STATEMENT OF CHARLENE HARRINGTON, PROFESSOR, DEPARTMENT OF SOCIAL AND BEHAVIORAL SCIENCES, UNIVERSITY OF CALIFORNIA, SAN FRANCISCO

Dr. HARRINGTON. Thank you. In response to a request by Congress, the Institute of Medicine completed a study entitled "Improving the Quality of Nursing Home Care" in 1986. This report recommended a number of important changes in the current system, including the resident assessment process, the Federal standards in the survey process and in the enforcement process.

After that, a broad coalition of consumer advocates and nursing home industry representatives supported the recommendations of this IOM report and it resulted in Congress passing the Nursing Home Reform Act as a part of OBRA 1987. This was a landmark piece of legislation and I am going to review five major components of this legislation this morning; first, the residents rights, quality of care and quality of life issues; staffing and services; resident assessment; the Federal standards and survey procedures; and the enforcement procedures.

First, the Act placed a new focus on resident rights and it enumerated these rights as being free from physical and mental abuse and from physical and chemical restraints, and the right to privacy and many other rights that are listed up here. The Act specified that facilities must care for residents in both a manner and an environment that promotes and enhances quality of life. Facilities must also ensure that each resident will attain and maintain the highest practicable level of physical, mental and social well-being.

Second, going back to 1987, you may remember that this was not the best of financial times, and yet Congress was willing to increase the staffing requirements in nursing homes. The RN minimum staffing requirements were set at 1 RN per 8 hours a day, 7 days a week, and 1 licensed nurse 24 hours a day. In addition, the Act required that there be sufficient staff to provide adequate care and it specified a whole series of services that must be offered, including rehabilitation, pharmacy, social services, dental services, and other such things.

The Act also required that there would be minimum training standards for nursing assistants which had not been in place before, and that was set at 75 hours of training and a competency exam. But one of the most important features of the Act was the new resident assessment requirements for each resident. Such assessments were required to be comprehensive and they must follow a uniform format, and facilities were required to use these assessments to develop individualized care plans.

After the Act was passed, HCFA had a contractor develop this resident assessment system and this resulted in the Minimum Data Set, or MDS, and this was talked about quite a bit yesterday. The MDS is an 8-page form with guidelines on how to conduct an assessment.

Can you put up the next poster?

There are 18 specific components of the Minimum Data Set and we won't go into all of these, but these include such things as cognitive functioning, physical functioning, communications, and hearing, and so on. And I think all of these are basic components that are really needed. It would be hard to think about any of these that could be eliminated.

Facilities must complete the MDS within 14 days of admission and every year after that, and then when there is a significant change in a resident's condition. The MDS has been tested and it has been found to be generally reliable and valid, and it is recognized as having made an important contribution to improving quality of care.

In addition, HCFA has a contractor at the University of Wisconsin that developed 30 quality indicators, or QIs as we call them,

using this MDS data. And these are in 12 domains and they are listed there, which include most of the most important problems that nursing home residents have—accidents, cognitive problems, infections, nutrition, and so on.

Moving on to the survey process, this was also changed by the Nursing Home Reform Act. The process requires surveying facilities about every 9 to 15 months, and then investigating any complaints made by residents or their family members. The surveys must be unannounced and they must include a registered nurse as a surveyor. There are 185 separate standards that HCFA has developed that nursing homes must comply with, excluding the life safety requirements that are also important.

Now, there is a very specific survey process and this has been listed here on the poster. Before the survey process starts, the surveyors are supposed to prepare for the survey offsite, look at the data and plan their survey. There is an entrance conference, a tour of the facility, and then surveyors select the residents that they are going to interview during the survey process.

But one of the most important parts of the Nursing Home Reform Act was the change that required surveyors to actually observe and interview the patients and the families because in the past many of these surveys were done looking at the resident records, and we heard yesterday about some of the problems with resident records not always being accurate.

Finally, after the survey is completed by the surveyors, deficiencies are developed if there are problems. There is an exit conference. The surveyors write up the deficiencies and they categorize the deficiencies in the post-survey period and then they follow up, if they need to, on visits.

Eight years after the Nursing Home Reform Act was passed, HCFA developed its enforcement guidelines and these went into effect on July 1, 1995. On the second poster there you can see a scope and severity grid that was created by HCFA to guide the surveyors in this process. There are four levels of—maybe we could take down that first poster so we can see the second one better.

There are four levels of severity and three levels of scope. For severity, the most severe category is immediate jeopardy to the life and safety of the patients. The third level is actual harm to the patients. The second level is no actual harm, but the potential for harm, and then the first level is no harm and minimal potential for harm. These are all important because this is how the remedies are set up.

The CHAIRMAN. Can I interrupt you? I am not going to stop you. We just had a vote, so the way we are going to do this—I am going to go vote and Senator Collins and Senator Breaux will stay here, and then I will come back and we will just keep the meeting going. So when you are done, the next panel will join you and be introduced if I am not back, but I will hurry.

Dr. HARRINGTON. Thank you.

If a facility is found to be causing immediate jeopardy to the residents, then the Secretary of Health and Human Services is required to take immediate action either by putting temporary new management into the facility or by terminating the facility's participation in the Medicare and Medicaid program.

If there is not immediate jeopardy, the Department has a whole range of sanctions that they can offer and these are listed here. They include denial of Medicare and Medicaid payments, civil money penalties up to $10,000, the transfer of residents, State monitoring, and plans of correction.

After these regulations were put into place, then HCFA also developed an operations manual that specified in more detail what surveyors should do, and there were also a number of informal changes that were adopted by HCFA and sent out to the States. A part of this was creating a category called "substantial compliance." This is where facilities in the lowest level, even though they had deficiencies, they still could be considered to be in compliance.

But the most important category was called "substandard care," and this is where facilities have deficiencies in one of three areas, either resident behavior and facility practices, quality of care, or quality of life. If these deficiencies in those areas are serious, then it is deemed to be substandard care, and it depends on where these violations occur on the grid.

The State operations manual allows facilities with good records to correct the deficiencies and not have to be sanctioned. It also encouraged the limited use of the denial of payments and that those should only be used for the most serious problems. For the civil money penalties, which were an important part of OBRA and the enforcement law, a moratorium was placed on these penalties until 1997. And now the civil money penalties are still advised to be of limited use only in the most serious situations.

The definition of "widespread" was changed by HCFA so that it has to be for all residents in a facility and not just for residents, say, on one wing of the facility or residents with a particular problem. In addition, the revisit policy was changed so that facilities only have to be revisited if they are in the top most severe categories of deficiencies.

So, in summary, I would like to say that Congress has made a major step forward in passing the Nursing Home Reform Act and it has very important provisions for consumers. What we are going to be talking about here today is how the Act has been implemented and whether it is working.

Thank you very much.

[A description of the Federal Nursing Home Survey and Regulation process follows:]

THE FEDERAL NURSING HOME SURVEY AND REGULATION PROCESS

Prepared for the U.S. Senate Special Committee on Aging
July 28, 1998

Charlene Harrington, Ph.D., R.N.
School of Nursing
University of California, San Francisco

In response to a request by Congress, the Institute of Medicine completed a study entitled Improving the Quality of Care in Nursing Homes in 1986. The Institute of Medicine report recommended major changes in the resident assessment process, the federal standards and the survey process for nursing homes certified by Medicare and Medicaid, and in the federal enforcement process. The recommendations were the basis for the formation of a broad coalition of consumer advocates and industry representatives that supported the Nursing Home Reform Act, which was passed by Congress in OBRA 1987. The Nursing Home Reform Act had five major components: (1) resident rights, quality of life, and quality of care; (2) staffing and services; (3) resident assessment, (4) federal standards and survey procedures, and (5) enforcement procedures.

The Act placed a new focus on resident rights. These include such areas as: being free from physical and mental abuse; being free from physical and chemical restraints; and right to privacy; and a right to voice grievances. The Act also placed a new focus on quality of life and quality of care. It specified that facilities must care for residents in a manner and an environment that promotes the maintenance and enhancement of quality of life. Facilities also must provide services so that each resident will attain or maintain the highest practicable physical, mental, and psychosocial well-being.

The Act also recognized the importance of staff and services. The Act increased the RN minimum staffing requirements to 1 RN Director of Nursing, 1 RN 8 hours per day seven days a week (who could also be the Director of Nursing), and 1 licensed nurse (RN or LVN/LPN) on 24 hours per day. Overall, facilities were required to provide sufficient staff to provide adequate

care. The Act specifies the minimum services that nursing homes must provide. These include: nursing services and specialized rehabilitation, social services, pharmaceutical services, dietary services, an on-going activities program, and dental services. The Act also made a major step forward in setting minimum training standards for nursing assistants. These include not less than 75 hours of training and nursing assistants must pass a competency evaluation before they can become a regular employee and they must attend regular in-service education.

One of the most important components of the Act was the new Resident Assessment requirements. The Act required that facilities must complete a resident assessment on each resident. Such assessments were to be comprehensive and follow a standardized and uniform format, and they had to be completed and signed by RN. The facilities were also required to complete and implement an individualized care plan for each resident. After the Act was passed, HCFA contracted with the Research Triangle Institute to develop a resident assessment system that used a Minimum Data Set (MDS) in 1990. The MDS was developed an eight page form for the resident assessment, along with detailed guidelines for completing the assessment and special guidelines for special resident problems that were identified. The components of the MDS include: background information, cognitive patterns, communication and hearing, mood and behavior, physical functioning, and other components. Facilities must complete the MDS for each resident within 14 days of admission and annually. In addition they are required to review the MDS for every resident each quarter and to complete a new MDS whenever there is any significant change in the resident's condition.

The MDS has been tested and found to have high reliability and validity and it generally is recognized has having made a major contribution to improving the resident assessments and care provided by nursing facilities. Congress required facilities to submit the resident assessment data to the state survey agencies in an electronic form after July 1988.

HCFA developed a contract with the University of Wisconsin to develop and test Quality Indicators using the MDS data. A set of 30 Quality Indicators have been developed which include: accidents, behavioral/emotional problems, clinical problems, cognitive problems, elimination and continence problems, infection, nutrition, physical functioning, psychotropic drugs, quality of life, sensory/communication problems, and skin care. These QIs can be used by facilities to monitor quality of care and by state survey agencies to: (1) identify residents that should be reviewed during the survey process and (2) to identify potential problem facilities.

The Nursing Home Reform Act also made major changes in the survey process. This includes conducting regular surveys of facilities about every 9-15 months and after any change of ownership. In addition, state agencies must investigate complaints about facilities and monitor facility compliance with the regulations. Surveys must be unannounced and must include registered nurses as surveyors. The state surveyors must not have conflicts of interest with the facilities they survey and they must have comprehensive training. The findings from the survey process must be made available to the public and posted in the facility.

HCFA established detailed survey procedures which are published as transmittal letters. There are two types surveys: (1) standard surveys that include a casemix stratifie dsample of residents to examine indicators of medical, nursing, rehabilitative care, dietary, activities, sanitation, infection control and physical environment. There are about 185 separate standards that facilities must meet (excluding the life safety requirements). The extended surveys are for those facilities are found to be providing substandard care under the standard survey. The extended survey uses an expanded sample of residents in the facility to identify the causes of substandard care.

The survey process is detailed by HCFA and includes: (1) offsite survey preparation; (2) an entrance conference and on-site preparation; (3) a tour of the facility; (4) the sample selection; (5) information gathering which includes observation, interviews of residents and

family members, record reviews, and interviews of the resident council; (6) the deficiency determination process; (7) exit conference; (8) writing the statement of deficiencies; (9) categorizing the deficiencies; and (10) the post survey process and follow-up.

HCFA also released detailed enforcement regulations and procedures that were effective in July 1995. These procedures require surveyors to categorize deficiencies by severity at four levels: (1) no actual harm with a potential for minimal harm; (2) no actual harm but a potential for more than minimal harm; (3) actual harm that is not immediate jeopardy; and (4) immediate jeopardy to resident health and safety. The scope of deficiencies are categorized as: (1) isolated; (2) a consistent pattern; and (3) widespread.

HCFA has states that if a facilities immediately jeopardizes the health or safety of residents, the Secretary shall take immediate action to remove the jeopardy and correct the deficiencies through specified remedies such as temporary management or terminate the facility's participation in Medicare and Medicaid. If the facility does not jeopardize the health and safety of residents, then other remedies may be imposed. These include: denial of Medicare and Medicaid payments for all residents or newly admitted residents, civil money penalties (up to $10,000), transfer of residents, state monitoring, a directed plan of correction and other remedies.

In addition, HCFA imposed an informal dispute resolution process where facilities have the opportunity to meet with state officials regarding the deficiencies but this is not to delay the imposition of remedies. This process is not a requirement of OBRA 1987. HCFA has a formal hearing process which allows for hearing for civil money penalties.

In summary, Congress made a major step forward in enacting the Nursing Home Reform Act. It includes many important new protections for consumers and established a sound basis for improving the (1) standards for nursing facilities, (2) the survey process, and (3) the enforcement process.

OBRA 1987 – NURSING HOME REFORM ACT

NEW FOCUS ON RESIDENT RIGHTS

- Choice of physician and treatment
- Free from physical and mental abuse
- Right to privacy and treatment with dignity
- Right to have confidential records
- Right to have needs and preferences met
- Right to voice grievances
- Right to appropriate transfer and discharge

NEW FOCUS ON QUALITY OF LIFE

Facilities must care for residents in a manner and an environment that promotes, maintains, or enhances quality of life.

NEW FOCUS ON QUALITY OF CARE

Facilities must provide services so that each resident will attain or maintain the highest practicable physical, mental, and psychosocial well-being

REQUIREMENTS FOR BASIC SERVICES AND ACTIVITIES

- Nursing services
  - 1 RN Director of Nursing
  - 1 RN 8 hours per day 7 days per week (maybe the same as the DON)
- 1 Licensed nurse 24 hours per day
  - Nursing assistants must have 75 hours of training and pass a competency exam
  - Staffing must be sufficient to provide adequate care
- Specialized rehabilitation
- Social services
- Pharmaceutical services
- Dietary services
- On-going activities program
- Dental services

OBRA 1987 -- RESIDENT ASSESSMENT REQUIREMENTS

FACILITIES MUST COMPLETE RESIDENTS ASSESSMENTS FOR EACH RESIDENT THAT ARE

- Must be comprehensive and accurate
- Must use a standardized format
- Must be conducted by a RN

HCFA REQUIREMENTS FOR A MINIMUM DATA SET (MDS) FOR EACH RESIDENT

- Completed with 14 days of admission
- Reviewed every quarter
- Completed when any significant change occurs
- Completed annually
- Use of a multi-disciplinary team
- Completion of resident assessment protocols (RAPS) for special problems

THE MINIMUM DATA SET INCLUDES

- Background information
- Cognitive patterns
- Communication and hearing
- Mood and Behavior
- Physical functioning
- Continence
- Disease diagnosis
- Health conditions
- Oral and nutritional status
- Skin Conditions
- Activity patterns
- Medications
- Treatments and procedures
- Discharge potential

QUALITY INDICATORS DEVELOPED FROM MDS DATA

- Accidents
- Behavioral and emotional
- Clinical
- Cognitive
- Elimination and continence
- Infection
- Nutrition
- Physical functioning
- Psychotropic drugs
- Quality of life
- Sensory and communication
- Skin care

USES OF QUALITY INDICATORS

- Facilities can monitor & improve their own care
- Surveyors can identify residents to review during the survey process
- Surveyors can identify potential problem facilities for targeted surveys

OBRA 1987 -- STATE AGENCY SURVEY PROCESS

FREQUENCY AND BASIC REQUIREMENTS FOR SURVEYS

- Be conducted between 9 months to 15 months
- Be conducted within 2 months of any change in ownership, administration or management
- Must be unannounced in advance
- Must use teams with registered nurses
- Surveyors must not have conflicts of interest and must have comprehensive training
- Must investigate complaints and monitor facility compliance
- Must disclose survey findings to the public

TYPES OF FACILITY SURVEYS

Standard Survey

Includes a casemix stratified sample of residents to examine indicators of medical, nursing, rehabilitative care, dietary, nutrition, activities, sanitation, infection control and physical environment

Extended Survey

Uses an expanded sample of residents in facilities which were found to have substandard care under the standard survey and is designed to review and identify the casemix of substandard care

STATE SURVEY PROCESS FOR FACILITIES

Task 1: Offsite Survey Preparation
- Identify areas of concern
- Identify residents for sample
- Identify special survey team needs

Task 2: Entrance Conference/ On-Site Preparation
- Confirm special resident populations
- Asks for information about the facility

Task 3: Initial tour of the facility

Task 4: Sample Selection of Residents
(about 12 residents for each 100 beds)
Should include:
- Heavy care and light care residents
- Interviewable and non-interviewable
- Special problems
- New admissions
- Under age 55
- Other

Task 5: Information Gathering
- Observations of the facility and residents
- Informal and formal interviews of residents
- Resident record reviews
- Group interviews of resident council members
- Interviews of family members and friends

Task 6: Information Analysis for Deficiency Determination

Review and analyze all information to determine whether the facility has failed to meet 1 or more requirements

Determine whether to conduct an extended survey

Task 7: Exit Conference

Task 8: Writing the Statement of Deficiencies

Task 9: Deficiency Categorization

Task 10: Post Survey Revisit and/or Follow-up

Senator Breaux [presiding.] Thank you very much, Dr. Harrington. I have a number of questions I would like to get into with you, but what we are going to do is bring up the other witnesses this morning and do it as a panel and ask you to please stay with this panel.

I would ask to join with you Dr. William Scanlon, who is Director of Health Financing and Systems, Government Accounting Office, and Dr. Andrew Kramer, who is research director and associate professor at the University of Colorado Health Sciences Department. Welcome to both of you and we would be pleased to take your testimony.

Dr. Scanlon, we have you listed. You go ahead.

STATEMENT OF WILLIAM J. SCANLON, DIRECTOR, HEALTH FINANCING AND SYSTEMS ISSUES, HEALTH, EDUCATION, AND HUMAN SERVICES DIVISION, UNITED STATES GENERAL ACCOUNTING OFFICE

Dr. SCANLON. Thank you very much, Senator Breaux, and thank you and the committee for inviting me to discuss the findings in our report that was released yesterday on nursing home care in California.

We undertook this work at the request of you, Senator Breaux, and Chairman Grassley, when you were concerned last year about allegations that were brought to the committee that in 1993 more than 3,000 residents from almost 900 California nursing homes had died allegedly due to poor care they received in those homes. These allegations, as you know, were based on an analysis of those residents' death certificates.

In response, you asked us to address two questions, whether those allegations regarding care provided in 1993 had merit, and, second, how successful Federal and State agencies have been more recently at identifying care problems in California nursing homes and correcting them. Answering these two questions really involved two separate studies, one focused on the care in 1993 and the other on care provided more recently in all California nursing homes.

I should perhaps acknowledge at the outset that we recognize the somewhat unusual nature of these questions for the General Accounting Office. Since they involve the appropriateness and adequacy of nursing and medical care, they should be addressed by clinical experts in these areas. A nurse on our own staff does have extensive expertise in quality of care reviews and nursing care for elderly persons. She did serve as a full-time member of the team for this study.

To assure our findings had a solid foundation, we also hired two registered nurses with advanced degrees in gerontological nursing and clinical expertise in nursing home care as consultants to review patients' medical records. We also received assistance from Dr. Andrew Kramer, who is here today, in reviewing conclusions from those resident record reviews. He also agreed to have his team, which is studying the quality of care review process for HCFA, to conduct quality of care reviews in two California nursing homes, enabling us to learn more about the effectiveness of the survey process. Finally, before our draft report was provided to anyone

for comment, we had it reviewed by four nationally renowned experts in geriatrics, gerontological nursing, and nursing home care.

To examine the first question you were concerned about, the allegations of avoidable deaths in 1993, we undertook a review of a sample of these residents' medical records to assess the care that they received. We knew at the outset that these reviews would be very time-consuming because, to be fair to the nursing homes, we believed it necessary to review the entire record from the time the resident was first admitted to the home.

For some residents, this meant several years of records. Therefore, it was only possible to review the care for a relatively small sample of residents in a reasonable time with our resources. We knew our sample would be too small to be reliable and representative of all 900 homes where these deaths occurred. We decided then to choose a sample that in certain circumstances might produce a stronger conclusion.

We chose a sample of residents from the homes with the highest incidence of alleged deaths due to poor care. Our reasoning was that if we did not find significant poor care in these seemingly most problematic homes, one could be more confident that poor care would not be found in the homes with few deaths that we did not sample. Unfortunately, our findings are very different. The two gerontological nurses reviewed the care of 62 residents in 15 homes. For 34 of these 62 residents, care was deemed unacceptable, and in 25 of those 34 cases care was believed to have threatened their health or safety.

As I mentioned, this review involved the entire resident's record from the date of first admission so that residents' underlying conditions and diseases and conditions developed outside the nursing home could be taken into account. The nurses were conservative in classifying residents' care as appropriate or inappropriate. When there was a doubt about the care provided, it was not classified as inappropriate.

The incidence of unacceptable care in this sample, the 55 percent, applies only to this sample. It establishes that some of the 3,000 identified residents who died received unacceptable care. It does not establish what proportion of the 3,000 got unacceptable care. To do so, given the time it takes to review one of these records, would require considerably more resources and time than we had available.

Let me now turn to the second question that you asked us to address, which was about the extent of current care problems and Federal actions to address them in California nursing homes. To look at this question, we examined information for almost all California nursing homes over the last 2 to 3 years. Our results are based on an analysis of deficiencies found by the State surveyors in one of the last two annual reviews for each home or during a complaint investigation in the homes. The number of homes we analyzed was 1,370, which is virtually all the homes operating in California at this time.

I would now ask you to turn your attention to the pie chart on my right. This chart is also included in our written statement on page 5. As you can see, we have grouped nursing homes in our analysis by the seriousness of their deficiencies. The figure next to

the pie chart shows you the relationship between the different pieces of the pie and how HCFA categorizes homes.

The piece that is shaded red at the bottom represents the most serious violations the California surveyors cited. Homes in the red wedge were those that were cited over the last 3 years for deficiencies that California surveyors classified as "immediate jeopardy" or "substandard care," using HCFA's definitions. It also includes homes that received a state citation for one of the two most serious level violations—for violations that either caused death or serious harm.

In California, State citations rather than Federal deficiency categories are generally used when a complaint investigation is done. As you can see, a total of 407 homes were cited for deficiencies at this level, accounting for nearly one-third of all the State's nursing homes.

Slightly more homes are in the "caused less serious harm category," the orange piece of the pie, which corresponds to HCFA's "actual harm" category, plus the equivalent State citation category. Some of the poor care identified in this category may be as serious as that identified in the homes in the red category.

Homes in the orange category are cited for care that caused harm to residents, but it is not care that was either as prevalent poor care as homes in the red category or was not care that is a continuing threat to residents. In our report, we provide actual examples of the deficiencies that surveyors cited at different levels, allowing the seriousness of each one to speak for itself.

As troubling as this data is, from what we learned and what you heard yesterday, they likely understate the extent of serious care problems for several reasons. You heard yesterday about how the predictability of the annual survey allows homes to be ready when surveyors arrive, about how falsified resident records can provide a misleading picture of the care that has been provided. You will hear from Dr. Kramer on how the survey methods could be made more effective to detect instances of poor care.

The nurse on our staff had a personal experience with the predictability of surveys. At one of the homes she visited with nurses working with Dr. Kramer and with State surveyors, the only surprise for the home was that we were there. The nursing home staff had a room ready for the State surveyors, but did not have one ready for us and did not know immediately where our nurses should sit to review records. We are encouraged by the fact that both the State and HCFA have recently indicated they intend to address this predictability issue head-on by varying the scheduling and timing of standard surveys, with a set amount to be done on weekends and evenings.

We think also it is worth considering another way to address the predictability of annual surveys, and that is to allow State agencies to divide the standard survey into two or more reviews focusing on different areas at different times. Both HCFA and the Department of Health Services in California have reservations about this suggestion, contending that dividing the survey would make it less effective and more expensive. While we recognize that altering the survey's scope and timing will no doubt require careful thought, we believe that doing so not only provides the possibility of eliminating

the predictability of surveys, but could also increase the frequency of surveyors visiting problem homes.

In my remaining time, I would like to turn quickly to a few of the enforcement findings. Our analysis indicates that HCFA and the State often fall short of their goal of ensuring that homes with serious deficiencies correct them and remain free of future problems. We identified that 1 out of 11 homes had repeated serious violations. Specifically, 122 California homes containing more than 17,000 beds were cited on two consecutive annual surveys for deficiencies involving harm to residents. These are deficiencies in the "actual harm" or higher range, the orange and the red categories on those charts.

Only one-fourth of these facilities, or 33 of the homes, had any Federal sanctions that actually took effect. This is not to say that the process to impose sanctions was not initiated in many cases, but they only took effect in one-fourth of the over 100 homes. Why is this?

HCFA and the State's standard practice is to have the State grant all but a few homes, regardless of their past performance, a month or a month-and-a-half grace period to correct deficiencies without a remedy or penalty taking effect. In recent years, California has granted 98 percent of its non-compliant homes this grace period, which is actually slightly lower than the national average, which is 99 percent.

In our report, we describe an example of a California home that surveyors have cited 4 years consecutively for deplorable treatment of residents with pressure sores, and each year was granted a grace period to correct its deficiencies. Following Federal policy, the State agency allowed the home to submit a corrective action plan after each survey and subsequently found the home each year to have achieved compliance. Not surprisingly, such homes have virtually no incentive to correct problems for the long term. In our report, we recommend eliminating the grace period for any home with such repeated, serious violations.

As for the ultimate Federal sanction, termination, few homes are ever terminated from the Medicare and Medicaid programs. Since July 1995, only 16 of the roughly 1,400 California homes have been terminated. Fourteen have been reinstated. Of these, 11 have been reinstated under the same ownership that they had before termination. Of the 14 reinstated homes, at least 6 have subsequently been cited with new deficiencies that harmed residents since their reinstatement.

Let me say in conclusion that Medicare and Medicaid are the nursing home industry's biggest customers. In certifying which homes their beneficiaries may enter and receive coverage and which homes can benefit from providing program beneficiaries care, HCFA and the States have a responsibility to assure that the care they are purchasing by participating homes is adequate and appropriate. Too often, this responsibility has not been met in California.

We and State surveyors themselves found too many cases in which the very basic needs of residents, such as eating, drinking, being clean, dry and pain-free, were not being met. Our findings regarding homes that repeatedly harm residents suggest that the unarguable goal of nursing homes' sustained compliance with qual-

ity of care standards often eludes HCFA and the State of California.

We are concerned about the gap between stated goals and actual outcomes. In 1995, HCFA enunciated its emphasis on encouraging sustained compliance and appropriately sanctioning deficient providers. With its newest report released just last week, once again HCFA is pledging reforms and renewed efforts on several fronts. We support these initiatives to strengthen the survey and enforcement process in order to improve care and protection for the residents. But we also believe that continued vigilance and support from the Congress will be needed to ensure that these pledges of improved Federal and State oversight of nursing home care will be fully realized.

Thank you very much, Mr. Chairman. I am happy to answer any questions you have.

The CHAIRMAN. Thank you very much, Dr. Scanlon. Before Dr. Kramer gives his testimony, I would like to say that Dr. Scanlon is the Director of Health Financing Systems at the General Accounting Office. He has worked for over 20 years to improve quality of care found in nursing homes. He is here, as is known, to present his findings as the lead person in this area that I asked to have investigated last October, and I thank him and his team very much for their work.

[The prepared statement of Dr. Scanlon follows:]

United States General Accounting Office
GAO
Testimony

Before the Special Committee on Aging, U.S. Senate

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CALIFORNIA NURSING HOMES

Federal and State Oversight Inadequate to Protect Residents in Homes With Serious Care Violations

Statement of William J. Scanlon, Director
Health Financing and Systems Issues
Health, Education, and Human Services Division

GAO/T-HEHS-98-219

Mr. Chairman and Members of the Committee:

Thank you for inviting me to discuss our findings on nursing home care in California. The federal government has a major stake in nursing home care, having paid the nation's roughly 17,000 homes $28 billion in 1997 through the Medicare and Medicaid programs. While the public relies on nursing homes to provide care to one of the most vulnerable segments of our population, allegations were raised to your Committee that some 3,000 residents died in more than 900 California nursing homes in 1993 as a result of malnutrition, dehydration, sepsis from improperly treated urinary tract infections, and other serious conditions for which they did not receive acceptable care.

The information I am presenting today is based on our recently issued report to your Committee.[1] Although I will begin with the care problems found through reviewing medical records for a sample of 62 residents who died in 1993, the majority of my comments will focus on our analysis of the current information on the quality of care in all California nursing homes. This analysis focused on care problems identified in recent state and federal quality reviews that California conducted in the last 2 or 3 years; obstacles to federal and state efforts to identify care problems; and implementation of federal enforcement policies to ensure that homes correct problems identified and then sustain compliance with federal requirements. The federal and state agencies with oversight responsibility for homes receiving funds from Medicare and Medicaid are the Health Care Financing Administration (HCFA) and the state of California's Department of Health Services (DHS). Together, they oversee care in the more than 1,400 California nursing homes, representing more than 141,000 resident beds. Medicare and Medicaid paid these homes approximately $2 billion in 1997 to care for nursing home residents.

In brief, we found that despite the presence of a considerable federal and state oversight infrastructure, a significant number of California nursing homes were not and currently are not sufficiently monitored to guarantee the safety and welfare of nursing home residents. We came to this conclusion, for the most part, by using information from California's DHS reviews of nursing home care covering 95 percent of the state's nursing homes and HCFA data on federal enforcement actions taken.

Looking back at medical record information from 1993, we found that, of 62 resident cases sampled,[2] residents in 34 cases received care that was unacceptable. However, in the absence of autopsy information that establishes the cause of death, we

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[1]California Nursing Homes: Care Problems Persist Despite Federal and State Oversight (GAO/HEHS-98-202, July 27, 1998).

[2]Our criteria for inclusion in the sample were that a case came from a home with at least 5 of the allegedly avoidable deaths and at least 5 such deaths per 100 beds. The 62 cases in our sample were drawn randomly and came from 15 nursing homes.

cannot be conclusive about whether this unacceptable care may have contributed directly to individual deaths.

As for the extent of care problems currently, between July 1995 and February 1998, California surveyors cited 407 homes–nearly a third of the 1,370 homes in our analysis–for care violations they classified as serious under federal or state deficiency categories. Moreover, we believe that the extent of current serious care problems portrayed in these federal and state data is likely to be understated. The predictable timing of on-site reviews, the questionable accuracy and completeness of medical records, and the limited number of residents' care reviewed by surveyors in each home have each likely shielded some problems from surveyor scrutiny.

Finally, even when the state identifies serious deficiencies, HCFA's enforcement policies have not been effective in ensuring that the deficiencies are corrected and remain corrected. For example, DHS surveyors cited about 1 in 11 California homes–accounting for over 17,000 resident beds–twice in consecutive annual reviews for violations involving harm to residents. (The national average was slightly worse–about one in nine homes were cited twice consecutively for violations of federal requirements involving harm to residents.) Nevertheless, HCFA generally took a lenient stance toward many of these homes. California's DHS, consistent with HCFA's guidance on imposing sanctions, grants 98 percent of noncompliant homes a 30- to 45-day grace period to correct deficiencies without penalty, regardless of their past performance. Only the few homes that qualify as posing the greatest danger are not provided such a grace period. In addition, only 16 of the roughly 1,400 California homes participating in Medicare and Medicaid have been terminated from participation, most of them have been reinstated quickly, and many have had subsequent compliance problems. Recognizing shortcomings in enforcement, California officials told us that they launched a pilot program this month intended to target for increased vigilance certain of the state's nursing homes with the worst compliance records.

BACKGROUND

The federal responsibility for overseeing nursing homes belongs to HCFA, an agency of the Department of Health and Human Services (HHS). Among other tasks, HCFA defines federal requirements for nursing home participation in Medicare and Medicaid and imposes sanctions against homes failing to meet these requirements. HCFA funds state survey agencies to do the on-site reviews of nursing homes' compliance with Medicare and Medicaid participation requirements. In California, DHS performs nursing home oversight, and its authority is specifically defined in state and federal law and regulations. As part of this role, DHS (1) licenses nursing homes to do business in California; (2) certifies to the federal government, by conducting reviews of nursing homes, that the homes are eligible for Medicare and Medicaid payment; and (3) investigates complaints about care provided in licensed homes.

To assess nursing home compliance with federal and state laws and regulations, DHS relies on two types of reviews–the standard survey and the complaint investigation. The standard survey, which must be conducted no less than once every 15 months at each home, entails a team of state surveyors spending several days on site conducting a broad review of care and services with regard to meeting the assessed needs of the residents.[3] The complaint investigation involves conducting a targeted review with regard to a specific complaint filed against a home.

The state and HCFA each has its own system for classifying deficiencies that determines which remedies, sanctions, or other actions should be taken against a noncompliant home. For standard surveys, California's DHS typically cites deficiencies using HCFA's classification and sanctioning scheme; for complaint investigations, it generally uses the state's classification and penalty scheme.

Table 1 shows HCFA's classification of deficiencies and the accompanying levels of severity and compliance status.

Table 1: HCFA's Deficiency Classification System

HCFA deficiency category	Level of severity	Compliance status of home cited for this deficiency
Immediate jeopardy to resident health or safety	Most serious	Noncompliant
Actual harm that does not put resident in immediate jeopardy	Serious	Noncompliant
No actual harm, with potential for more than minimal harm	Less serious	Noncompliant
No actual harm, with potential for minimal harm	Minimal	Substantially compliant

HCFA guidance also classifies deficiencies by their scope, or prevalence, as follows: (1) isolated, defined as affecting a limited number of residents; (2) pattern, defined as affecting more than a limited number of residents; and (3) widespread, defined as affecting all or almost all residents.

[3]The standard survey is used not only to meet HCFA's certification requirement but also to ensure that a home continues to meet its state licensing requirements.

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REVIEW OF RECORDS FOR 1993 DEATHS UNCOVERED SERIOUS CARE PROBLEMS

Our work indicates that 34 residents–more than half of our sample of 62 of California's nursing home residents who died in 1993–received unacceptable care. In certain of those cases, the unacceptable care endangered residents' health and safety; however, without an autopsy that establishes the cause of death, we cannot be conclusive about whether the unacceptable care directly led to any individual's death. Nevertheless, the care problems we identified were troubling, such as unplanned weight loss and failure to properly treat pressure sores. For example:

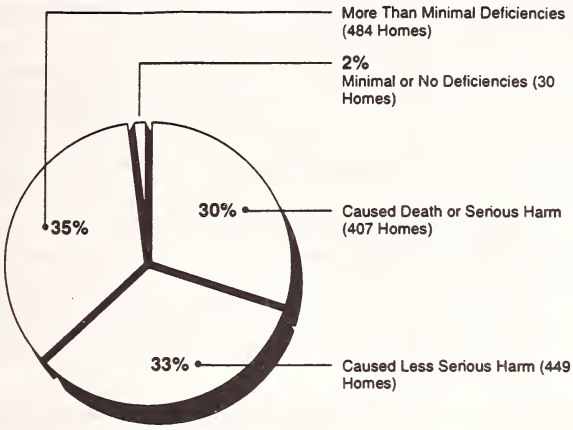
- A resident lost 59 pounds–about one-third of his weight–over a 7-week period. Only a small share of the weight loss was attributable to fluid loss. Until 2 days before the resident's death, the nursing home staff had not recorded his weight since the day he was admitted to the home or notified the physician of the resident's condition.

- A resident was admitted to a nursing home with five pressure sores, four of which exposed the bone. Although the physician ordered pain medication during treatments that removed the blackened dead tissue from her sores, the resident's medical record indicated that she received pain medication only three times during 5 weeks of daily treatments. The resident, who was not in a condition to verbalize her needs, was reported in the nursing notes to moan whenever this procedure was done without prescribed pain medication.

STATE'S RECENT QUALITY REVIEWS REVEAL SIGNIFICANT CARE PROBLEMS IN NEARLY ONE-THIRD OF ALL HOMES

DHS surveyors identified a substantial number of homes with serious care problems through their annual standard surveys of nursing homes and through ad hoc complaint investigations. Our analysis of these data shows that, between 1995 and 1998, surveyors cited 407 homes, or nearly a third of the 1,370 homes included in our review, for serious violations classified under the federal deficiency categories, the state's categories, or both. (See fig. 1, "Caused Death or Serious Harm.") These homes were cited for improper care leading to death (26 homes), posing life-threatening harm to residents (259 homes), other serious violations involving improper care (111 homes), or falsifying or omitting key information from medical records (11 homes).

Figure 1: Distribution of 1,370 California Nursing Homes by Seriousness of Violations Cited, 1995-98



The four wedges in figure 1 correspond to the federal deficiency categories shown in table 1 and include comparable-level deficiencies cited using the state's separate classification scheme, as shown in table 2.

Table 2: Categorization of Deficiencies by HCFA and by California DHS

Description of deficiency categories	HCFA deficiency category	State deficiency category
Caused death or serious harm	Immediate jeopardy Substandard care	Improper care leading to death, imminent danger or probability of death, intentional falsification of medical records, or material omission in medical records.
Caused less serious harm	Actual harm	Violations of federal or state requirements that have a direct or immediate relationship to the health, safety, or security of a resident.
More than minimal deficiencies	Potential for more than minimal harm	California has no state citation directly equivalent to the federal category.
Minimal or no deficiencies	Potential for more than minimal harm/no deficiencies	California has no state citation directly equivalent to the federal category.

Within the "caused death or serious harm" group are homes cited for several types of federal violations, including "improper care leading to death" and "life-threatening harm." Following is an example from the 26 homes California surveyors cited for improper care leading to death:[4]

– A resident who was admitted to a home for physical therapy rehabilitation following hip surgery died 5 days later from septic shock, caused by a urinary tract infection. The home's staff failed to monitor fluid intake and urine output while the resident was catheterized and afterwards. Nursing home staff failed to notify a physician as the resident's condition deteriorated. When his family visited and found him unresponsive, they informed the staff and his physician was contacted.

[4]The subclassification "improper care leading to death" does not include all residents who died in homes cited for violations related to resident's care, because the category "life-threatening harm" can also include such violations and associated deaths.

His physician ordered intravenous antibiotics, but the staff were unable to get the intravenous line in place and continuously functioning until 8 hours had passed. The resident died 3 hours later.

The next example is from the 259 homes California surveyors cited for life-threatening harm:

- Because the home lacked sufficient licensed nursing staff on duty, residents did not receive treatments, medications, or food supplements as ordered. One resident's medical record indicated that, although a licensed nurse had noted the individual's deteriorating physical condition a half hour before she died, there was no evidence that the nurse continued to assess the resident's vital signs, administered oxygen as prescribed by a physician's order, or notified the attending physician and family about the resident's deteriorating condition.

We also determined that cases of poor care were not limited to the 407 homes noted. State surveyors documented instances of serious quality problems that they categorized as federal deficiencies in the range of "actual harm" or "potential for more than minimal harm" or as lower-level state citations. Examples of these are included in our report.

PREDICTABILITY OF SURVEYS, QUESTIONABLE RECORDS, AND SURVEY LIMITATIONS HINDER EFFORTS TO IDENTIFY CARE PROBLEMS

The deficiencies that state surveyors identified and documented only partially capture the extent of care problems in California's homes, for several reasons. First, some homes can mask problems because they are able to predict the timing of annual reviews or because medical records sometimes misrepresent the care provided. In addition, state surveyors can miss identifying deficiencies because of limitations of the methods used in the annual review–methods established in HCFA guidance on conducting surveys–to identify potential areas of unacceptable care.

Predictability of On-Site Reviews

One problem masking the extent of poor care involves the scheduling of standard surveys. The law requires that a standard survey be unannounced and that it be conducted roughly every year.[5] Because many California homes were reviewed in the same month–sometimes almost the same week–year after year, homes could often predict

[5]Technically, the standard survey must begin no later than 15 months after the last day of the previous standard survey, and the statewide average interval between standard surveys must not exceed 12 months.

the timing of their next survey and prepare to reduce the level of problems that may normally exist at other times.

At two homes we visited, we observed that the homes' officials had made advance preparations–such as making a room ready for survey officials–indicating that they knew the approximate date and time of their upcoming oversight review. After we discussed these observations with California DHS officials, they acknowledged that a review of survey scheduling showed that the timing of some homes' surveys had not varied by more than a week or so for several cycles. DHS officials have since instructed district office managers to schedule surveys in a way that will reduce their predictability.

The issue of the predictable timing of surveys is long-standing. More than a decade ago, the Institute of Medicine called for adjusting the timing of the surveys to make them less predictable and maximize the element of surprise.[6] Subsequently, the Omnibus Budget Reconciliation Act of 1987 (OBRA 87) nursing home legislation and HCFA's implementing guidance attempted to address the predictability issue. However, a subsequent HCFA-conducted poll of nursing home resident advocates in most states and a 1998 nine-state study by the National State Auditors Association found that predictable timing of inspections continues to be a problem.

Questionable Records

Inaccurate or otherwise misleading entries in medical records can mask care problems or make it more difficult for surveyors to prove that care problems exist. We found such irregularities among the medical records we reviewed, a problem widely recognized in long-term-care research.[7] Discrepancies appeared in about 29 percent of the 1993 records we reviewed. The following two examples of such discrepancies were found in the medical records we reviewed:

- During the hospital stay of a nursing home resident, doctors discovered that the resident was suffering from a fractured leg and that the fracture had occurred at least 3 weeks before the hospitalization. The nursing home's records were missing the clinical notes for the same 3-week period preceding the resident's hospital stay,

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[6]Institute of Medicine, Improving the Quality of Care in Nursing Homes (Washington D.C.: Institute of Medicine, 1986), pp. 32-33.

[7]Jeanie Kayser-Jones and others, "Reliability of Percentage Figures Used to Record the Dietary Intake of Nursing Home Residents," Nursing Home Medicine, Vol. 5, No. 3 (Mar. 1997), pp. 69-76, and John F. Schnelle, Joseph G. Ouslander, and Patrice A. Cruise, "Policy Without Technology: A Barrier to Improving Nursing Home Care," The Gerontologist, Vol. 37, No. 4 (1997), pp. 527-32.

thus omitting any indication that an injury had occurred, how it might have occurred, or how it might have been treated.

- Although a resident's medical record showed that each day she consumed 100 percent of three high-caloric meals and drank four high-protein supplements, the resident lost 7 pounds–10 percent of her total weight[8]–in less than a month. The implausibility of the resident's weight loss under these conditions raises major questions about the accuracy of the medical records regarding nutritional intake.

California state surveyors have also identified serious discrepancies in medical records. The following example is one of the cases they cited:

- A home's treatment records named a staff member as having provided two residents with range-of-motion exercises nine separate times. It was later determined that the staff member was not working at the home when the treatments were reportedly provided.

HCFA's Protocol for Identifying Potential Care Problems

A third monitoring weakness that can hinder surveyors' detection of care problems involves HCFA's guidance on selecting cases for review to help surveyors identify potential instances and prevalence of poor care. HCFA policy establishes the procedures, or protocol, that surveyors must follow in conducting a home's standard survey. However, HCFA's protocol–designed to increase the likelihood of detecting problems with care–does not call for randomly selecting a sufficient sample of residents. Instead, it relies primarily on the use of the individual surveyor's professional expertise and judgment to identify resident cases for further review.

In contrast, our expert nurses, in reviewing current medical records to identify areas with potential for poor care, took a stratified random sample–cases from different groups of the home's more fragile as well as average residents. Each sample was of sufficient size to estimate the prevalence of problems identified. In addition, the nurses used a standard protocol to collect and record quality-of-care information from chart reviews, staff interviews, and data analyses to ensure that the information was in a consistent format across the various individuals interviewed and documents reviewed.

For two homes receiving their annual surveys, we compared the findings of the DHS surveyors, who followed HCFA's survey protocol, with the findings of our expert

[8]According to medical experts, a 5-percent weight loss in a month is considered a significant loss.

nurse team, who accompanied the state surveyors and conducted concurrent surveys. The methodology our expert nurses used examined primarily quality-of-care outcomes and related issues, whereas state surveyors, following federal guidance, reviewed this and 14 additional areas, such as social services, resident assessment, and transfer and discharge activities. As a result, DHS surveyors sought and found deficiencies in some important areas that our expert nurses did not document. However, in the quality-of-care area, our nurses found serious care problems that DHS surveyors did not find, including unaddressed weight loss, improper pressure sore treatment, and ineffective continence management.

HCFA'S ENFORCEMENT POLICIES INEFFECTIVE IN BRINGING HOMES WITH SERIOUS, REPEATED VIOLATIONS INTO SUSTAINED COMPLIANCE

We also examined the efforts of the state and HCFA to ensure that the homes cited for serious deficiencies were correcting their problems and sustaining compliance with federal requirements over time. Encouraging sustained compliance and appropriately sanctioning deficient providers are among HCFA's stated enforcement goals. However, we found that, under HCFA's policies, enforcement results often fall far short of those goals.

Between July 1995 and March 1998, DHS surveyors cited 1 in 11 homes, or 122 homes, in both of their last two surveys for conditions causing actual harm, putting residents in immediate jeopardy, or causing death.[9] These homes represent over 17,000 resident beds. The national compliance rate for about the same period and for the same repeated, serious harm deficiencies was slightly worse: about 1 in 9 homes, representing more than 232,000 beds, were cited.

However, HCFA enforcement policies have led to relatively few federal disciplinary actions taken against these homes in California. Before OBRA 87, the only sanction available to HCFA and the states to impose against such noncompliant homes, short of termination, was to deny federal program payments for new admissions. OBRA 87 provided for additional sanctions, such as denial of payment for all admissions, civil monetary penalties, and on-site oversight by the state ("state monitoring").[10] Nevertheless,

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[9]The data on deficiencies cited in standard surveys are contained in the OSCAR (On-Line Survey, Certification, and Reporting) System, a federal database maintained by HCFA.

[10]Other sanctions include third-party management of a home for a temporary period ("temporary management"); requirement for a home to follow a plan of correction developed by HCFA, the survey agency, or a temporary manager–with HCFA or survey agency approval–rather than by the home itself ("directed plan of correction"); and mandatory training of a home's staff on a particular issue ("directed in-service training").

these sanctions were seldom applied even to the 122 homes in our analysis cited twice consecutively for serious harm deficiencies. Specifically, only a fourth–33 homes–had any federal sanctions that actually took effect.

HCFA Policies Lead to Lenient Enforcement Stance

HCFA's forgiving stance toward homes with a "ping-pong" history of compliance helps explain how these homes could repeatedly harm residents without facing sanctions. Generally speaking, HCFA sanctioning policy divides homes into two groups: those that the state agency is instructed to refer to HCFA immediately to initiate sanctioning and those for which the state agency is permitted to grant a grace period first to correct deficiencies without the imposition of federal sanctions.[11]

To qualify for immediate referral under HCFA policy, homes must have been cited for deficiencies in the immediate jeopardy category or rated as a "poor performer." The criteria for meeting HCFA's poor performer definition include an intricate combination of immediate jeopardy and substandard quality-of-care deficiencies.[12] Since July 1995, when the federal enforcement scheme established in OBRA 87 took effect, 59 California nursing homes have been cited for immediate jeopardy deficiencies and about 25 have been designated poor performers. HCFA guidance permits the state to broaden the definition of poor performer, but California has chosen not to do so.[13]

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[11]Homes in the immediate referral group do not necessarily receive sanctions. If homes come into substantial compliance before sanctioning is scheduled to take effect, HCFA rescinds the sanction.

[12]Under HCFA's definition of poor performer, a home must have been cited on its current standard survey for substandard quality of care and have been cited in one of its two previous standard surveys for substandard quality-of-care or immediate jeopardy violations. HCFA also has a special definition for "substandard quality of care," as follows: the deficiencies must constitute immediate jeopardy to resident health and safety in one of three categories of deficiencies, or belong to the same three categories and include the following combination of severity and scope levels: pattern of or widespread actual harm that is not immediate jeopardy, or widespread potential for more than minimal harm.

[13]For example, California could include in the poor performer definition a home's record of violations cited in the course of complaint investigations. Unlike standard surveys, complaint investigations are generally unexpected and provide surveyors a unique opportunity to gauge care issues in a home's everyday environment. Because these investigations can uncover serious quality-of-care problems, including complaint-generated violations in a home's poor performer record would give regulators a more complete picture of a home's compliance history.

Noncompliant homes that are not classified in the immediate jeopardy or poor performer categories do not meet HCFA's criteria for immediate referral for sanctioning, even though some may have seriously harmed residents. HCFA policy permits granting a grace period to this group of noncompliant homes, regardless of their past performance. Between July 1995 and May 1998, California's DHS gave about 98 percent of noncompliant homes a grace period to correct deficiencies. For nearly the same period (July 1995 through April 1998), the rate nationwide of noncompliant homes receiving a grace period was higher–99 percent–indicating that the practice of granting a grace period to virtually all noncompliant homes is common across all states.

Following HCFA policy, DHS is not required to and does not appear to take into account a home's compliance history for the bulk of noncompliant homes receiving a grace period. Our report describes a home that, despite being cited by DHS for the same violations–the unacceptable treatment of pressure sores–4 years consecutively, has continued to receive a grace period to correct its deficiencies following each annual review. We question the wisdom of granting such homes a grace period with no further federal disciplinary action.

For the few California homes that have had federal sanctions imposed, HCFA has been less than vigilant. In principle, sanctions imposed against a home remain in effect until the home corrects the deficiencies cited and until state surveyors find, after an on-site review (called a "revisit") that the home has resumed substantial compliance status. However, if some of the home's deficiencies persist but are no more serious than those in the "potential for harm" range, HCFA policy is to forgo a revisit and accept the home's own report of resumed compliance status. HCFA officials told us this policy was put into place because of resource constraints. In California, however, this policy has been applied even to some of the immediate referral homes that, on a prior revisit, have been found out of substantial compliance.

Our report describes the case of an immediate referral home for which HCFA twice accepted the home's self-reported statement of compliance without having DHS independently verify that the home had fully corrected its deficiencies:

- In an October 1996 survey, DHS cited the home for immediate jeopardy and actual harm violations, including improper pressure sore treatment, medication errors, insufficient nursing staff, and an inadequate infection control program. By early November 1996, however, surveyors had found in an on-site review that the problems had abated, although they had not fully ceased. A week later, the home reported itself to HCFA as having resumed substantial compliance.[14] HCFA accepted this report without further on-site review. About 6 months later (May

[14]A home reports itself to HCFA as being in compliance by sending HCFA a letter called a "credible allegation of compliance."

1997), in the home's next standard survey, DHS found violations that warranted designating the home as a poor performer. On a revisit to check compliance in July 1997, surveyors found new, but less serious, deficiencies. In August 1997, however, when the home reported itself in compliance, HCFA accepted the report without further verification. Between October 1996 and August 1997, HCFA imposed several sanctions but rescinded them each time it accepted the home's unverified report of resumed compliance status.[15]

Similarly, HCFA's level of vigilance appears to be inadequate for homes that have been terminated and later reinstated. HCFA has the authority to terminate a home from participation in Medicare and Medicaid if the home fails to resume compliance. However, termination rarely occurs and is not as final as the term implies. In the recent past, California's terminated homes have rarely closed for good. Of the 16 homes terminated in the 1995 through 1998 time period, 14 have been reinstated. Eleven have been reinstated under the same ownership they had before termination. Of the 14 reinstated homes, at least 6 have been cited with new deficiencies that harmed residents since their reinstatement, such as failure to prevent avoidable accidents, failure to prevent avoidable weight loss, and improper treatment of pressure sores.

A home that reapplies for admission is required to have two consecutive on-site reviews–called reasonable assurance surveys–within 6 months to determine whether the home is in substantial compliance with federal regulations before its eligibility to bill federal programs can be reinstated. HCFA officials told us that HCFA cannot prevent a home from being reinstated if it is in substantial compliance during these reviews. However, HCFA has not always ensured that homes are in substantial compliance before reinstating them. Consider the following example:

- A home terminated on April 15, 1997, had two reasonable assurance surveys on April 25 and May 28, 1997. Although the nursing home was not in substantial compliance at the time of the second survey, HCFA considered the deficiencies minor enough to reinstate the home on June 5, 1997. The consequence of termination–stopping reimbursement for the home's Medicare and Medicaid

[15]In the October 1996 survey, HCFA imposed a civil monetary penalty that went into effect October 3 and was stopped from further accrual on November 8 when HCFA determined that federal requirements were met, based on the survey that had found lower-level deficiencies. In the May 1997 standard survey, HCFA imposed a civil monetary penalty to take effect in May 1997 and a denial of payment for new admissions sanction to take effect in July 1997, both of which HCFA stopped in August 1997 when the home reported that it was in compliance.

beneficiaries–was in effect for no longer than 3 weeks.[16] About 3 months after reinstatement, however, the home was cited for harming residents. DHS surveyors investigating a complaint found immediate jeopardy violations resulting from a dangerously low number of staff. In addition, surveyors cited the home for providing substandard care. Dependent residents, some with pressure sores, were left sitting in urine and feces for long periods of time; some residents were not getting proper care for urinary tract infections; and surveyors cited the home's infection control program as inadequate.

California DHS Is Piloting Alternative Enforcement Procedures Targeting a Small Group of Most Seriously Deficient Homes

California DHS officials recognized that the state–in combination with HCFA's regional office–has not dealt effectively with persistently and seriously noncompliant nursing homes. Therefore, beginning in July 1998 and with HCFA's approval, DHS began a "focused enforcement" process that combines state and federal authority and action, targeting providers with the worst compliance records for special attention.

As a start, DHS has identified about 34 homes with the worst compliance histories–approximately 2 in each of its districts. Officials intend to conduct standard surveys of these homes about every 6 months, rather than the normal 9-to-15-month frequency. In addition, DHS expects to conduct more complete on-site reviews of homes for all complaints received about these homes. DHS officials also told us that the agency is developing procedures–consistent with HCFA regulations implementing OBRA 87 reforms–to ensure that, where appropriate, civil monetary penalties and other sanctions stronger than a corrective action plan will be used to bring such homes into compliance and keep them compliant. In addition, DHS has begun to screen the compliance history of homes by owner–both in California and nationally–before granting new licenses to operate nursing homes in the state. State officials told us that they will require all homes with the same owner to be in substantial compliance before any new licenses are granted.

CONCLUSIONS AND RECOMMENDATIONS

The responsibility to protect nursing home residents, among the most vulnerable members of our society, rests with nursing homes and with HCFA and the states. In a number of cases, this responsibility has not been met in California. We and state surveyors found cases in which residents who needed help were not provided basic care–

[16]Under Medicare and Medicaid rules, terminated nursing homes may be paid for care of residents in the home on the date of termination for up to 30 days after the termination takes effect.

not helped to eat or drink; not kept dry, clean, or free from feces and urine; not repositioned to prevent pressure sores; not monitored for the development of urinary tract infections; and not given pain medication when needed.

As serious as the identified care problems are, many care problems may escape the scrutiny of surveyors. Homes can prepare for surveyors' annual visits because of their predictable timing. Homes can also adjust resident records to improve the overall impression of the home's care. In addition, DHS surveyors can overlook significant findings because the federal survey protocol they follow does not rely on an adequate sample for detecting potential problems and their prevalence. Together, these factors can mask significant care problems from the view of federal and state regulators.

HCFA needs to reconsider its forgiving stance toward homes with serious, recurring violations. Federal policies regarding a grace period to correct deficiencies and to accept a home's report of compliance without an on-site review can be useful policies, given resource constraints, when applied to homes with less serious problems. However, regardless of resource constraints, HCFA and DHS need to ensure that their oversight efforts are directed at homes with serious and recurring violations and that policies developed for homes with less serious problems are not applied to them.

Under current policies and practices, noncompliant homes that DHS identifies as having harmed or put residents in immediate danger have little incentive to sustain compliance, once achieved, because they may face no consequences for their next episode of noncompliance. Our findings regarding homes that repeatedly harmed residents or were reinstated after termination suggest that the goal of sustained compliance often eludes HCFA and DHS. Failure to bring such homes into compliance limits the ability of federal and state regulators to protect the welfare and safety of residents.

Our report makes recommendations to the HCFA Administrator to address these issues. Although our report focuses on selected nursing homes in California, the problems we identified are indicative of systemic survey and enforcement weaknesses. Our recommendations therefore target federal guidance in general so that improvements are available to any state experiencing problems with seriously noncompliant homes. Thus, through HCFA's leadership, federal and state oversight of nursing homes can be strengthened nationally and residents nationwide can enjoy increased protection. In summary, we are recommending that HCFA revise its guidance to states in order to reduce the predictability of on-site reviews, possibly by staggering the schedule or segmenting the survey into two or more reviews; revise methods for sampling resident cases to better identify the potential for and prevalence of care problems; and, for those homes with a history of serious and repeated deficiencies, eliminate the offer of a grace period for resuming compliance and substantiate all of the home's reports of resumed compliance with an on-site review.

HCFA, DHS, and nursing home industry representatives have reviewed our report. Acknowledging that the findings were troubling, HCFA officials informed us that they are planning to make several modifications in their survey and enforcement process. DHS also suggested a number of changes–in addition to its new, focused enforcement program–intended to improve the federal survey and enforcement process. Last week, the administration announced a series of actions related to federal oversight of nursing homes, including night and weekend survey visits and increased inspection of homes with a record of noncompliance. HCFA, DHS, and industry representatives generally concurred with our recommendations, although both HCFA and DHS expressed some reservations about segmenting the standard survey. They contend that dividing the survey into two or more reviews would make it less effective and more expensive. However, we believe that this option–which could largely eliminate the predictability issue and increase the frequency of surveyors' presence at problem homes–warrants consideration of the benefits to be derived relative to the disadvantages that were raised.

Finally, despite the survey and enforcement modifications promised by HCFA and DHS, we remain concerned about the gap between stated goals and results. In 1995, HCFA enunciated its emphasis on encouraging sustained compliance and appropriately sanctioning deficient providers. Its practices since that time, however, argue for swift and significant changes, as illustrated in California by the persistence of problem homes with little federal sanctioning. We support the administration's recent initiative to strengthen the survey and enforcement process. However, we also believe that continued vigilance by the Congress is needed to ensure that the promised changes in federal and state oversight of nursing home care are implemented.

Mr. Chairman, this concludes my prepared statement. I would be happy to answer any questions you or the Committee Members may have.

(101753)

The CHAIRMAN. Dr. Kramer is research director for the Center on Aging, and is also a professor of geriatric medicine at the University of Colorado Health Sciences Center. He has spent many years investigating and evaluating quality indicators within the nursing home community.

Dr. Kramer.

STATEMENT OF ANDREW M. KRAMER, M.D., RESEARCH DIRECTOR, CENTER ON AGING, UNIVERSITY OF COLORADO HEALTH SCIENCES CENTER

Dr. KRAMER. Thank you, Mr. Chairman and members of the committee. I would like to begin my statement by highlighting three key points. First, we found severe quality of care problems in California nursing homes that we surveyed for GAO. One of these facilities had extremely poor care and the other, while not as bad, also had significant quality of care problems.

Second, the State survey, conducted concurrently, found no significant quality of care problems in the worst facility and only some of the problems that we identified in the second facility. How many other extremely poor facilities passed the survey without identification? A stronger enforcement system or any quality improvement initiative will be of limited value if the survey does not accurately identify poor-performing facilities.

Third, the accuracy of the nursing home survey could be improved, but it will require major changes in the way it is conducted: changes in the number of residents reviewed, the type of information that is collected, the way information is collected and, once collected, in the way it is used. Such a revision may not have to cost more.

We reviewed quality of care in two California nursing homes during February 1998, at the same time as the State nursing home survey was conducted. Our review approach is based on recommendations of the 1986 Institute of Medicine report and has been used in over 100 nursing homes. The findings were unquestionable.

As illustrated in Exhibit 1, quality problems included avoidable hospitalizations due to insufficient monitoring, one death in each facility in which the response to the resident's deteriorating status was too little and too late, falls with fracture that were not well-documented or may have been prevented occurred in one facility. A highly restrictive restraint was used without documented need. Both facilities had high rates of residents dressed in hospital gowns late in the day, and one facility had a high rate of residents who were unclean and ungroomed.

Nutritional problems were found in both facilities, with low-weight residents not receiving food supplements and continuing to lose weight, and inadequate nutrition even when residents were tube-fed. A high skin infection rate was found in one nursing home, accompanied by poor infection control precautions. And in both facilities, there was a high rate of bed sores among residents who were not mobile and not kept dry nor repositioned.

From two nursing homes, we cannot generalize about the quality of care in the State of California. Nevertheless, the State nursing home survey should be able to detect these problems.

How did we find these problems? We use a two-stage review conducted by nurses with extensive experience in long-term care who use laptop computers.

In the first stage, they collect information on more than 80 residents. They are selected to meet two objectives. First, we want to focus on residents who are most vulnerable to quality problems, such as new admissions to the nursing homes, or those at risk for pressure sores. Second, we want to obtain a random sample so that we can generalize to the entire facility.

We collect the information from four sources—resident observation and interview, the nursing home chart, the nursing home staff, and the Minimum Data Set that was described earlier. And we assess 75 different quality of care standards. We compare each facility's rate of poor outcomes with a national norm from a group of more than 60 facilities. Where the facility has a higher rate than the norm, we conduct a second-stage review which is more detailed in those selected areas.

An example of this two-stage process is provided in Exhibits 2 and 3 for the indicator of low weight and no supplements. As you can see, the first step is to look at this random sample of 40 residents who are long-staying residents in the facility. We determine if each resident has a body mass index less than 22 kilograms per meter squared, which is just a weight/height ratio. We also determine if they are receiving high-protein on high-calorie supplements.

Both of these issues are supported by literature. A 30- to 60-percent increase in mortality has been found in individuals with a body mass index less than 22, and it has also been found that high-protein or high-calorie supplements can improve body mass index and weight. We exclude residents with terminal illness or those who refuse to eat. Then we determine the percentage who are low-weight and not receiving supplements. In this facility, we had 11 out of 38, or 29 percent. We compared this with the national norm of 18 percent. Clearly, this facility was an outlier requiring further review.

So we go to the second stage. In the second stage, we look at issues relating to that problem. In this case, we reviewed continued weight loss, and problems such as bed sores that require adequate nutrition to prevent or treat. We looked at the presence of a dietary assessment and whether dietary recommendation were followed.

We recorded the findings of each case, determining whether this low weight was actually justified, because the facility did everything they could to improve weight, or if there were some areas where quality of care could have been improved and actual harm or potential harm occurred. In this facility, two of the cases were justified, two had potential harm, and in four cases we found actual harm.

What could HCFA do to improve the survey process? I suggest the following five changes. First of all, examine larger resident samples, including both a random sample to determine general rates of poor outcome and focused samples of vulnerable populations. Second, review quality of care for new admissions to the nursing home. They are a very vulnerable population.

Third, collect uniform quality of care data using a structured protocol at each facility, including multiple sources. The MDS information is a start, but it is not sufficient. Four, target areas for review based on facility-wide outcomes of care. We will never have the resources to review every resident in every nursing home, so we need to choose the facilities and the areas to review based upon comparison with norms. Fifth, recognizing that both measuring and assuring quality is a very difficult job, we need to work together to make the most appropriate use of the latest knowledge and technology. That is the reason why I came here today.

Thank you for this opportunity.

[The prepared statement of Dr. Kramer follows:]

"Betrayal: The Quality of Care in California Nursing Homes"
United States Senate Special Committee on Aging
Hearing Testimony

Andrew M. Kramer, M.D.
Research Director
Center on Aging, University of Colorado Health Sciences Center
July 28, 1998

We reviewed the quality of care in two California nursing homes during February 1998 at the same time as the state nursing home survey was conducted. Our review approach is based on recommendations of the 1986 Institute of Medicine report[1] and has been used in over 100 nursing homes in three different national evaluations of nursing home survey activities funded by HCFA.[2,3,4]

The findings were unquestionable; we found important, facility-wide quality of care problems in both nursing homes. As illustrated in Exhibit 1, these included avoidable hospitalizations due to insufficient monitoring in one facility, and one death in each facility in which the response to the resident's deteriorating status was too little and too late. Care was appropriate, however, in association with deaths of six other residents, many of whom required comfort care only. Falls with fractures that were not well documented or may have been prevented occurred in one facility. In the other facility, a highly restrictive restraint was used without documented need. Both facilities had high rates of residents dressed in hospital gowns late in the day and one facility had a high rate of residents who were unclean.

Nutritional problems were found in both facilities with low weight residents not receiving food supplements and continuing to lose weight; and inadequate nutrition even when a resident was tube-fed in one facility. A high skin infection rate was found in one nursing home, accompanied by poor infection control precautions. In both facilities, there was a high rate of bed sores among residents who were not mobile, and not kept dry nor repositioned.

While no quality assessment approach is perfect, the medical literature, as well as common sense, provide support for these quality standards. From two nursing homes, we cannot generalize about the quality of nursing home care throughout California. Nevertheless, the state nursing home survey should detect these quality problems. But we have found similar problems with the survey in other states as well.

How did we find these problems?
We used a two-staged review conducted by two nurses with extensive experience in long-term care and quality assessment, who used laptop computers. In the first stage, we collected information on more than 80 residents. Residents were selected based on two objectives: 1) to focus on the residents most vulnerable to quality problems such as new admissions and those at risk for bed sores; and 2) to obtain a random sample of current residents that could be used to generalize results to the whole facility.

We collected uniform information from four different sources: resident observation/interview, the nursing home chart, the nursing home staff, and the Minimum Data Set (MDS) in order to assess 75 different quality standards. We compared each facility's rate of poor outcomes with a norm from a group of more than 60 facilities. Where the facility had a higher rate than the norm, we conducted a second stage: a more detailed review of selected residents.

Exhibits 2 and 3 provide an illustration of one quality standard (or indicator). For the 40 long-stay residents in our sample, we determined whether the Body Mass Index, the ratio of weight and height, was less than 22 kilograms per meter squared: a standard set by the Nutritional Screening Initiative in 1992 and which research has shown is associated with a 30%-60% increase in mortality.[5,6] We determined whether these residents were receiving some type of high protein or high calorie supplements to improve their nutritional status.[7,8] After excluding residents with terminal illness or who refused to eat, we determined the percentage of residents in the facility who were both low weight and not receiving supplements. For this facility the rate was 29% compared with the national norm of 18%; this quality standard required further review.

In the second stage (Exhibit 3), we reviewed selected cases looking for evidence of continued weight loss, problems such as bed sores that require adequate nutrition to prevent or treat, the presence of a dietary assessment, and follow through on dietary plans. We recorded the findings for each case, determining whether the low Body Mass Index was justified, because the facility did all that could be done for that resident, or potential or actual harm occurred due to inadequate care. We found two cases that were justified, but six cases of either actual or potential harm.

What could HCFA do to improve the survey process?
I suggest the following five changes to the nursing home survey (Exhibit 4):

(1) Examine larger resident samples including both a random sample to determine general rates of poor outcomes and focused samples of vulnerable populations.
(2) Review quality of care for new admissions, one of the most vulnerable populations. Because of declining hospital lengths of stay, nursing homes are confronted by new admissions with greater acute care needs, which they are not always prepared to treat.
(3) Collect uniform quality of care data using a structured protocol at each facility. Multiple sources of information should be used, including: resident observation/interview, chart review and staff interview. The MDS is a resident assessment instrument, but not a quality assessment instrument. It is completed by the facility staff and does not measure many important outcomes.
(4) Target areas for further review based on facility-wide outcomes of care. We will never have the resources to review every resident in every nursing home, so we need to choose the facilities and areas to review based upon comparison with national norms.
(5) Recognizing that both measuring and assuring quality is a very difficult job, we need to work together to make the most appropriate use of the latest knowledge and technology. That is the reason why I am here today. Thank you for this opportunity.

References

1. Institute of Medicine (IOM). Improving the Quality of Care in Nursing Homes. National Academy Press; Washington, D.C. 1986.

2. Kramer, Andrew, James Grigsby, and Darcy Cooper. "Analysis of the Validity of Quality of Care Determinations." Chapter 4 in Evaluation of the Nursing Home Survey Process. Abt Associates, Bethesda, Maryland. December 1996.

3. Kramer, Andrew, Carol A. Hrincevich, Jon Pool, Darcy Cooper, and Diane Carter. Pilot Test of a Staged Quality of Care Survey Using Quality Indicator Profiles. Center for Health Policy Research, Denver, Colorado. September 1995.

4. Kramer, Andrew, Jacqueline Cahill Kowalsky, Michael Lin, and Mary Ecord. "Comparison Between the Joint Commission Accreditation Survey and a Concurrent Nursing Home Quality Survey." Chapter 9 in Report to Congress on HCFA Survey. Health Care Financing Administration. March 1998.

5. Nutrition Screening Initiative. Nutrition Interventions Manual for Professionals Caring for Older Americans. Executive Summary. Washington, D.C.: Nutrition Screening Initiative, 1992.

6. Tayback, Matthew, Shiriki Kumanyika, and Elsbeth Chee. "Body Weight as a Risk Factor in the Elderly." Arch Intern Med. 1990;150:1065-72.

7. Gray-Donald, Katherine, Helene Payette, Veronique Boutier, and Sonya Page. "Evaluation of the Dietary Intake of Homebound Elderly and the Feasibility of Dietary Supplementation." Journal of the American College of Nutrition. 1994;13(3):277-84.

8. Gants, Ruth. "Detection and Correction of Underweight Problems in Nursing Home Residents." Journal of Gerontological Nursing. 1997;23(12):26-31.

Illustrative Findings

- Hospitalizations: (1 NH) insufficient monitoring
- Deaths: (2 NHs) slow response to deteriorating status
- Falls with fracture: (1 NH) poorly documented/avoidable
- Highly restrictive restraint: (1 NH) insufficient evaluation
- Residents not dressed: (2 NHs) hospital gowns in p.m.
- Residents unclean/ungroomed: (1 NH)
- Low weight and no supplements: (2 NHs) losing weight
- Skin infections: (1 NH) poor infection control precautions
- Bed sores: (2 NHs) not kept dry and repositioned

Exhibit 1

First Stage Review for: Low Weight and No Supplements

① Random sample of 40 residents

② Determine if each resident:

- Had Body Mass Index < 22 kg/m^2
- Received high protein/high calorie supplements

③ Exclude residents with:

- Terminal illness
- Refusal to eat

④ Determine percentage low weight and no supplements:
11/38 = 29%

⑤ Compare with national norm = 18%

Exhibit 2

Second Stage Review for: Low Weight and No Supplements

⑥ Review each selected case in more detail for evidence of:

- Continued loss of weight
- Problems associated with poor nutrition (e.g., bed sores)
- Dietary assessment
- Follow through on plan

⑦ Record findings

- 2 justified
- 2 potential harm
- 4 actual harm

Exhibit 3

What Can Be Done to Improve the Survey Process?

① Larger samples - randomly selected; focus on vulnerable populations.

② Review new admissions.

③ Collect uniform data using structured protocols. Include: resident observation, chart review and staff interview. MDS not sufficient.

④ Target facilities/problems based on outcome patterns compared to national norms.

⑤ Use current knowledge/technology.

Exhibit 4

The CHAIRMAN. Well, we thank you for your testimony. Sorry for the interruptions that we have had this morning, but we just had final passage of a piece of legislation.

I would suggest if any of my colleagues are under time constraints, I would——

Senator MOSELEY-BRAUN. I have a question for everybody.

The CHAIRMAN. Well, you go ahead.

Senator MOSELEY-BRAUN. Thank you very much, Mr. Chairman.

Senator Reid. Would the gentlelady yield?

The CHAIRMAN. I am sorry. You know what? I will let you speak, but I need to apologize to Dr. Harrington. We are not ready for questions yet because we have not heard her testimony. She gave an overview and I forgot.

So why don't you quickly hurry here?

Senator Reid. I would ask unanimous consent that my statement be made part of the record.

The CHAIRMAN. Yes, yes.

[The prepared statement of Senator Reid follows along with prepared statements of Senator Shelby and Senator Kohl:]

PREPARED STATEMENT OF SENATOR HARRY REID

Thank you Mr. Chairman. I am grateful for your attention to this disturbing situation. I would also like to thank all of the witnesses who have agreed to testify before this committee today.

One of the most difficult times for any family member is when they must make the decision to place a loved one in a nursing home. When reviewing this possibility, there are many factors to consider. The basic safety and well-being of a loved one should not have to be among these considerations. However, abuse and neglect ranging from malnutrition, dehydration, bedsores, and even rape are realities for many seniors in nursing homes today.

Before I continue, I want to take a moment to acknowledge that not every nursing home in the country is guilty of neglect and abuse. I know of many wonderful nursing homes that provide high-quality care to seniors, and these facilities should be commended for their work. It is also important to note that, although these hearings focus on the problems in California, I assure you that nursing home abuse and neglect is not limited to the confines of one State.

Although I was unable to attend yesterday's hearing in person, I am aware that several courageous individuals came before this committee to recount the nightmares they or their loved ones endured while in nursing homes. Equally horrifying were the memories of the nurses, doctors and nursing home aides who witnessed first-hand the neglect and abuse that took place on a daily basis in their facilities. While we cannot change what has already happened, we can listen closely to what these individuals told us yesterday, and learn from their experiences so that we may prevent similar tragedies from occurring again in the future. Each witness pointed to three systemic problems within their individual facilities—inadequate staffing levels, the predictable nature of state surveys, and lack of proper enforcement of established regulations.

As the largest single payer of nursing home care, the Federal government is charged with ensuring that our oldest, most vulnerable population receives quality care, and that our standards are strictly enforced. If we turn a blind eye to the serious lack of enforcement of nursing home standards in this country, we are no better than the facilities that condone negligent and abusive practices in their nursing homes.

As Senator Kohl mentioned yesterday, we have worked hard to improve the enforcement of nursing home standards. Last year, Senators Kohl, Grassley and I introduced legislation that would require criminal background checks of all prospective nursing home workers, and establish a national registry of individuals convicted of nursing home abuse. By identifying those who have mistreated seniors in the past, we can prevent these heinous crimes from reoccurring. Last week, we took an important first step in this direction when our amendment authorizing nursing homes and home health agencies to use the FBI criminal background check system was included in the Commerce, Justice, State Appropriations bill.

I am pleased that President Clinton has acknowledged this problem and called for tough new legislative and administrative actions to improve the quality of nursing homes. As the babyboom generation approaches retirement, it becomes even more important that we coordinate our efforts to ensure that seniors have access to quality care. As Senator Kohl indicated yesterday, we will be introducing the Administration's nursing home legislation later this week. I am pleased that this important bill will be modeled after our original legislation.

Although these efforts are a step in the right direction, it is still clear that a lot more must be done. And it must be done immediately. If we cannot provide protection for the 1.6 million seniors in nursing homes today, we certainly will not be equipped to accommodate the 4 million seniors expected to live in nursing homes by the year 2030.

Again, I thank the Chairman for convening these hearings and I look forward to listening to all of the panelists here today. Thank you.

PREPARED STATEMENT OF SENATOR RICHARD SHELBY

Good Afternoon. I want to thank Chairman Grassley for holding this important hearing. Although this hearing addresses the quality of care in California nursing homes, I am certain that the type of problems that we will hear about today are not confined only to California. Since the media picked up on this issue last week, my office has been contacted by constituents who have very serious concerns about the quality of care within some Alabama nursing homes.

The elderly that reside in nursing homes are some of the most vulnerable people in our society who are often victims of Alzheimer's disease and strokes. Unfortunately, in many cases their impairments make it difficult for them to communicate, and thus particularly vulnerable to neglect and abuse.

As members of Congress, and of the Aging Committee, we have an obligation to assure that an effective system is in place to identify nursing homes where neglect and abuse occur.

Once these bad actors are found, appropriate action must be taken to ensure that they comply with Federal regulation thereafter, or lose their ability to participate in the Medicare and Medicaid programs.

In part, I believe the growth which has occurred in the nursing home industry in recent years may have spawned the problems that will be discussed here today. I am concerned that the number of nursing home residents may be growing faster than the industry's capacity to provide effective care to them. In light of the fact that the "baby boom" cohort has yet to retire, I fear that things could get even worse.

Again, thank you Chairman Grassley for holding this hearing. In addition, I want to thank the witnesses for having the courage to come forward and share their stories. I look forward to learning how we can correct the current problems that exist, and how we can prepare for the even greater challenges I feel are in store for us when the "baby boom" generation retires.

PREPARED STATEMENT OF SENATOR HERB KOHL

Thank you, Mr. Chairman. Although I am deeply saddened by the circumstances that have made these hearings necessary, I thank all of the witnesses who have agreed to appear during these past two days.

Yesterday, we heard horrifying stories of patient abuse and neglect, both from family members of victims as well as from nursing home employees. I want to stress that I do believe that most nursing homes do a good job and provide high quality care to their patients. Still, the testimony we have heard indicates that too many people are suffering and dying in California nursing homes, and likely around the nation, due to malnutrition, dehydration, and inadequate efforts to prevent bedsores and infections.

This is absolutely inexcusable. We have laws and regulations already in place that should be preventing these problems, but they are not enforced in any meaningful way. Congress and the Administration must take action immediately. I look forward to hearing from all of the witnesses today about the serious problems in the current system, as well as their recommendations for us to fix it. We owe our nation's senior citizens—our mothers, fathers, grandparents, and siblings—nothing less than our strongest commitment to making sure they get the quality care they need and deserve.

The CHAIRMAN. This panel is not ready for questions yet. I am sorry. But if you have something you want to say, I would be glad to have you do that.

Senator MOSELEY-BRAUN. I hope that the witnesses in their testimony will address the question of the involvement or the ability of families to be involved in the survey/assessment process because it seems to me there can be no better source of information in many instances than the families and people who care about the residents in nursing homes in terms of their ability to interface with the process either at the State level or directly with HCFA. If you could respond to that, I would appreciate it.

The CHAIRMAN. Dr. Harrington, let me apologize once again. I am sorry.

Dr. HARRINGTON. Thank you. I just want to say that this hearing is somewhat of a deja vu experience for me because I was the director of licensing and certification in California in 1975, and at that time we held a number of hearings around the State and we heard many of the very same problems. And here we are in 1998 still trying to understand how to correct these problems. It is rather sad.

I want to present my data from my research and some of my recommendations for how HCFA could improve the problems with the survey and enforcement process, and I am going to make recommendations in five areas. One is that facilities with high percentages of resident problems should be targeted for more frequent surveys and enforcement actions.

Second, the current standards for the nursing staff are inadequate and need to be increased, and facilities with low nursing staff need to be targeted for more frequent surveys and enforcement actions. Third, the survey process needs to be more focused on the resident problems. Fourth, enforcement actions need to be tougher. Finally, I would like to talk about consumer advocacy and consumer information systems.

First, I have a poster here that presents the most common problems that nursing homes report in California in 1997–98, and this is using HCFA data from the OSCAR data set that is readily available for all nursing homes. And you can see there are very high percentages of urinary and bowel incontinence, restraint use, depression, contractures, and so on.

These problems have been consistently high in California over time, and the second chart shows, for example, the percentage of residents with pressure sores in California, which is the pink, compared to the national average, which is the blue. In some ways, California is very similar to the rest of the Nation in its problems, but we do know that 27 percent more residents have pressure sores in California. California residents are 51-percent more likely to have physical restraints. The residents are 32-percent more likely to have depression. The residents have more catheters. There are more residents on bed rest, and so on. Some of these problems have actually increased over the last 7 years, such as contractures have increased by 40 percent, rather than declining.

When surveyors go out to visit a facility, the facility fills out a form that tells all of these problems. The surveyors could use these forms and the data to target the facilities with the highest levels of problems, and an example is on the next poster where you see

restraint use in California. What we can see here is that 127 facilities have over a 50-percent restraint use. In other words, 50 to 90 percent of their residents are in restraints, and 14 facilities have 90 percent of their residents in restraints.

This is totally unacceptable, and we know who these facilities are right now. We have data on all of them. We have all their historic data and these facilities could be targeted. So we want HCFA to do this in the future. But more importantly, I think HCFA needs to develop guidelines for the surveyors when they do go out and look at these problems it will help the surveyors decide when the care is inadequate.

Now, the next issue is staffing, because in order to provide care for the problems that we see in nursing homes, the bottom line is we have to have adequate staffing. And this is the most fundamental problem in California nursing homes and in the Nation as a whole. We have statistics on the staffing levels for all facilities in the Nation and in California. You can see this poster with the pink.

What we know is that the average resident gets 68 minutes of nursing care, in total, per shift, and this includes all of the administrative staffing as well as the direct care. And this is inadequate. Now, the staffing has increased slightly by about 10 percent over the past 7 years, and it is about the same as in the Nation, but it is not sufficient.

We know that the average RN hours per resident is only 14 minutes per shift. Now, that is not adequate for supervision and for providing direct care and for looking at these serious problems that residents have. But this is the minimum Federal standard, so we need to change the minimum Federal standards.

We also know that the average nursing assistant has 12 residents to take care of, and it is impossible. We heard yesterday how sick the patients are and how frustrated the staff become. This results in high turnover rates and poor morale. So the bottom line is we need to do something about the Federal minimum staffing standards.

This blue chart in the center is difficult to read, but these are detailed staffing recommendations. What we are recommending based on consumer recommendations and nursing experts is that we should have 1 nurse to every 5 residents on the day shift, 1 to 10 on the evening, and 1 to 15 on the night shift, plus we need people to assist with feeding at meal times, 1 nurse to every 3 residents that need full assistance with feeding. And these people must be trained, unlike the current proposals for untrained people.

We want to see HCFA audit these facilities that have low staffing. This next poster shows the distribution of staffing, and we know which facilities are reporting very low staffing standards. These can be targeted right now for stronger penalties and enforcement actions by HCFA.

Moving to the next area, I would like to show the current deficiencies that are given out in California. The top ten deficiencies are given for clinical record violations, food and sanitation violations, poor care plans, and so on. These are important areas. But, in addition, the problems that were pointed out earlier need to be targeted. These are not being targeted as the top areas to be exam-

ined, so we want to see HCFA focus greater enforcement efforts on the special problems such as incontinence, dehydration, and so on.

Now, fourth, I would like to mention the issue about the decline in enforcement. This is what is so troubling because, nationally, we have seen a 42-percent decline in the average number of deficiencies given out to facilities since 1991. In California, we see that the deficiencies in the pink actually went up until 1993, and then California took a 42-percent decline in deficiencies.

So what we are trying to understand today is what is causing this decline in the enforcement activities. I am sorry that I don't have answers, but we need to encourage HCFA to streamline its enforcement process and try to do a better job of identifying substandard care.

The final issue is about consumer advocacy. One way to protect the public is to have active consumer advocacy groups. In California, we are very lucky because we have a statewide organization called California Advocates for Nursing Home Reform. It is a nonprofit group and I believe they testified before you last year.

Unfortunately, when we heard the testimony yesterday, several of the people that testified did not know about this organization, or they could have gotten some assistance for them. Partly, that is because this organization is operating on a shoestring, and I think that it is worthwhile for Congress to consider if there is some way to finance some of these consumer advocacy groups to continue doing their work. We have the National Citizens Coalition for Nursing Home Reform at the national level. That is a critical organization.

Also, the issue of consumer information is very important, and we were very pleased to hear about the President's initiative where he said he wants to establish a consumer information system on the Internet. I have been working with the consumer groups and faculty at the University of Wisconsin for a number of years trying to develop a consumer information system and we have shown that it can be effective.

So want to see this information be set up so that we can find out about all facilities in the Nation, including their resident characteristics, staffing ratios, deficiencies, the complaints, and we would like to see the enforcement records. All of this information is available now, except for the enforcement record but it is not made available to consumers by HCFA. We would like to see enforcement actions added to this HCFA system and distributed to the public.

So, in summary, I think there are things that can be done to improve the situation, and thank you for the opportunity to present these ideas.

[The prepared statement of Dr. Harrington follows:]

QUALITY OF CARE AND REGULATION IN CALIFORNIA NURSING HOMES

Prepared for the U.S. Senate Special Committee on Aging
Hearing Testimony, July 28, 1998

By

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My concern about poor nursing home quality of care developed when I was the Director of the Licensing and Certification regulatory program for the State of California in 1975-76. I served on the Institute of Medicine's Committee on Nursing Home Regulation in 1986 that made recommendations for passage of the Nursing Home Reform Legislation in OBRA 1987. Today, I present data and recommendations from five years of research on nursing homes in California and nationally to suggest five key areas where HCFA can improve the survey and enforcement process.

First, facilities with high percentages of resident problems that are the result in poor quality of care should be targeted for extended surveys and enforcement action. Second, current standards for nursing staff must be increased and facilities with low nursing staff levels must be identified and targeted by surveyors for enforcement actions. Third, the survey process should be improved by focusing on special problems such as poor nutrition and preventable deaths. Fourth, stronger enforcement actions need to be taken to encourage compliance with the existing regulations. Finally, consumer advocacy and consumer information systems are needed to inform the public about quality problems. Data are presented from the HCFA On-Line Survey, Certification, and Reporting (OSCAR) system from 1991-1997-98[a,1] for California on 1,345 certified nursing facilities with 123,922 beds.[b]

I. TARGETING FACILITIES WITH HIGH LEVELS OF RESIDENT PROBLEMS

Prevalence of Resident Problems

Nursing facilities report resident characteristics and problems at the time of each regular survey. See Figure 1. The most common problems of nursing home residents are: bladder

incontinence (49 percent of residents), bowel incontinence (43.5 percent), physical restraints (23.4 percent), depression (23.1 percent), and contractures (22.2 percent). Some of the conditions and problems of residents may be under-reported by facilities and some may be erroneous because they are not audited by state surveyors.

Incontinence. Incontinence is a common problem and requires that residents be assisted in toileting and given care to prevent accidents. Incontinence can be reversed in almost half of the individuals who develop it and can be improved in other individuals. [2-6] In the 1997-98 period, 49 percent of California nursing home residents had bladder incontinence and 43.5 percent had bowel incontinence. See Figures 2 and 3. Most residents with incontinence (96-97 percent) were not receiving bowel and bladder training programs appropriate for addressing their problems. The rates of bladder and bowel incontinence in California nursing facilities were similar to the U.S. averages. The rates of urinary and bowel incontinence have been consistently high during the 1991 though 1997-98 period. Those individuals with bladder and bowel problems frequently develop skin breakdown and pressure sores which can be painful and even life threatening. More important, residents with these problems suffer indignities and discomfort, which can be prevented by good nursing care.

Physical Restraints. Restraints are defined by HCFA as mechanical devices, materials, or equipment that restrict freedom of movement or normal access to one's body. Restraints may cause decreased muscle tone and increased likelihood of falls, incontinence, pressure ulcers, depression, contractures, and other problems. A number of studies have shown the value of reducing the use of restraints.[7-10] In California, restraints have declined by 12 percent (from 26.7 percent in 1991 to 23.4 in 1997-98). Although restraint use has declined somewhat in California, it is 51 percent above the national average (See Figure 4).

Depression. Of the total U.S. nursing home residents, 17.5 percent were reported to have depression in 1996. In California, 23.1 percent of residents were reported to be depressed in 1997-98, which is 32 percent higher than the national average.[6,11] Depression is one problem that nursing homes seek to prevent or reduce, and the high numbers in California nursing homes may either be a factor of better identification of the problem and/or the failure to address the psychosocial needs of residents.[6]

Contractures. One goal of nursing home care is to prevent contractures (joints which are immobilized) and to maintain joint function. Contractures can be a sign that residents are not receiving appropriate joint exercises and adequate care.[11-12] In California, 21.4 percent of nursing home residents had contractures in 1996 and 22.2 percent in 1997-98 (about the same rate as the national average). See Figure 5. In California, residents with contractures have increased by 40 percent, from 15.9 percent in 1991 to 22.2 percent in 1997-98. Only 16 percent of California residents were reported by nursing homes to have been admitted with contractures compared with 22.2 percent reported with contractures in 1997-98. The differences in admission rates and prevalence rates may represent differences between short-term and long term residents. It also suggests that some facilities are not providing adequate care to prevent the development of contractures.

Catheters. Urinary catheters are devices sometimes used for the convenience of facility staff rather than for medical necessity. Catheters should only be used when medically necessary because

they are associated with infections and discomfort.[11-14] In 1997-98, 9.6 percent of California nursing home residents had an indwelling urinary catheter, a rate 23 percent higher than the national average (in 1996). Moreover, the rate of catheter use in California has been persistently high since 1991. The use of urinary catheters can be prevented with proper nursing care of residents, including taking residents to the toilet frequently and with bladder training programs.

Physical Status and Immobility. One of the most important measures of resident characteristics is the extent to which individuals need assistance with the activities of daily living (ADLs). Three resident characteristics are considered to be particularly important in resource utilization studies: eating, transferring, and toileting.[11-13, 15] In the US, the overall average score for all three ADLs decreased from 6.1 in 1994 to 5.8 out of a possible 9 points for the most dependent residents in 1996.[c] California ADL scores are slightly higher than the national average (6.3 in 1994, 6.1 in 1996, and 6.1 in 1997-98) (no table shown). Limitations in ADLs may be related to poor health status upon admission and/or to the failure to maintain or prevent the decline in activities of daily living through appropriate exercise and nutrition.

Mobility is another important characteristic which indicates the level of physical functioning of residents.[11,13] In California, the percentage of residents who were bedfast was 9.3 in 1996 and 9.6 percent in 1997-98, or 16 percent higher than the national average. These higher rates may indicate inadequate care in some nursing homes where individuals are not kept active and out of bed. The average number of bedfast residents increased by 88 percent (from 5.1 in 1991 to 9.6 percent of residents) in the U.S.. Except when death is imminent, no resident should be bedfast.

Pressure Sores. Pressure sores are bruises or open sores on the skin (usually on the hips, buttock, heels or bony areas), from pressure or friction on the skin. Pressure sores may result in pain, infection, and can even be fatal. Good nursing care is generally able to prevent pressure sores from occurring and to ensure that the skin heals properly.[11-12] Pressure sores were problems for 8.8 percent of California nursing home residents compared with 6.9 percent of residents in the U.S. in 1996 (27.5 percent higher for California). See Figure 6. Pressure sores increased to 9.1 percent of residents in 1997-98. The 1997-98 data for California showed that only 5.9 percent of residents were admitted with pressure sores but 9.1 percent of residents had pressure sores at the time of the survey, or 54 percent higher than the number reported on admission.

Psychoactive Medications. The percent of residents receiving psychoactive medications is also a concern because high percentages, particularly of hypnotic medications may represent poor care.[8,16] Hypnotic and psychoactive medications may be used as chemical restraints in some facilities to control resident behavior rather than because of medical or clinical indications. California nursing home residents with psychoactive medications increased from 29.1 percent in 1991 to 39.5 percent in 1997-98 (a 36 percent increase). Although this rate is slightly below the national average, it remains high. Of California nursing home residents, 7.9 percent were given hypnotic medications. Regulations require nursing homes to review medications and to use such medications only when clinically indicated but this area needs regulatory attention.

Weight Gain or Loss. Weight gain or loss may be caused by several different factors but one common reason for weight loss is poor nutrition.[17-21] Many residents need assistance with eating, while others have difficulty swallowing food, dental problems, appetite loss, or other problems that put them at risk for malnutrition. Other residents become dehydrated from not receiving sufficient fluids. Of the total residents in California nursing homes, 7.7 percent had unplanned significant

weight loss or gain in 1997-98, compared with 8.6 percent nationally in 1995-96. Although California reports of weight loss are not high, weight loss is probably seriously underreported based on nursing home research studies.[17-21]

These resident problems have all been consistently high in California and nationally for the last seven years and California residents are more likely to report physical restraints and pressure sores than residents in other states. Some residents are admitted with problems but the data show more residents with problems than were admitted with problems, suggesting that some residents develop problems after admission to the nursing facilities because of poor care.

Targeting Facilities With Problems

One approach to improving the nursing home survey process is to identify facilities that report high percentages of patients with problems. These facilities should be targeted for more frequent surveys and extended surveys. For example, Figure 7 shows that 464 facilities in California have 11-15 percent of their residents in restraints, 349 have 26-50 percent in restraints, 127 have 51-90 percent in restraints, and 14 facilities have over 90 percent of residents in restraints. These facilities with high percentages need to be investigated and given sanctions if these restraints are unnecessary.

Figure 8 shows that 11 percent of facilities have 75 percent or more of residents with bladder incontinence, and about 30 percent of facilities have 11 percent or more with pressure sores, catheters, and weight gain or loss. Others have high percentages of residents with contractures. At the present time, nursing homes with these unusually high resident problems are not targeted for more frequent or more extended nursing home surveys.

Nursing homes are now required to submit comprehensive resident assessments completed on the minimum data set (MDS) forms to the states in a computerized format. The University of Wisconsin under a HCFA contract developed a set of 30 quality indicators (QIs) using the MDS data that are more accurate and comprehensive than the OSCAR resident data.[22] The QIs include 12 domains: accidents, behavioral and emotional problems, clinical problems, cognitive impairment, elimination and continence problems, infection control, nutrition and eating, physical functioning (bedfast and declines in ADLs), psychotropic drugs, quality of life indicators (restraints and inactivity), sensory/communication problems, and skin problems. Within the coming year, the MDS data will allow HCFA and states to monitor the QI changes in individual resident conditions over time and to identify residents and facilities that have unusually high rates of problems. Some states that participated in the HCFA casemix and quality demonstration project may be using these QI data for targeting their survey efforts. Other states like California will be able to use QI data in the future.

Recommendations. HCFA should require states to use data on resident problems to identify facilities with potential problems. Facilities with high percentages of resident problems should be targeted for more frequent and extended surveys to determine whether the quality of care is inadequate. Surveyors need more guidance in determining when an identified resident problem is the result of inadequate care and when the problem may be due to other factors. HCFA should develop detailed guidelines for determining when care is inadequate and/or harmful and the scope and severity of the inadequate/harmful care.

II. SETTING STANDARDS AND TARGETING FACILITIES WITH LOW STAFFING

In recognition of the low nurse staffing levels in nursing homes, the Nursing Home Reform Act (OBRA 1987) increased nurse staffing. Nursing care is critical to the provision of high quality services and nursing personnel provide the majority of care in nursing homes. Where nursing care fails to address the resident problems described above, poor and life threatening outcomes occur.

Current staffing levels in most facilities are inadequate to provide high quality of care. Figure 9 shows the nurse staffing levels for all facilities in California and in the U.S. The total nursing (registered nurses (RNs), licensed vocational/practical nurses (LVN/LPNs), and nursing assistants (NAs)) hours per resident day in California were 3.4 hours (68 minutes of care per 8 hour shift) in 1997-98.[d] These hours include all administrative time, indirect care time (e.g. charting) and direct care time. The overall hours increased about 10 percent in California over the seven year period. The staffing levels in California are approximately the same as the national average for the period, but there are wide variations in patterns across states.[1,23-25]

The average ratio of RNs was 0.7 hours (42 minutes) per resident day (See Figure 10), or 14 minutes per eight hour shift. This is an average of one RN for every 40 residents per day. This is completely inadequate to provide care and supervision but this meets the minimum federal standard which is for one RN Director of Nursing, one RN on duty for 8 hours a day seven days a week, and

one licensed nurse (either an RN and/or LPN/LVN) on duty around the clock for nursing facilities. Unfortunately, a facility with 35 beds has the same requirement for one RN as a 1,000 bed facility. Larger facilities have lower staffing levels and these lower staffing levels are associated with higher deficiencies of all types.[23-25]

The Nursing Home Reform law requires sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable level of physical, mental and psychosocial well-being of each resident. HCFA regulations also require nursing homes to base staffing patterns on the actual care needs of residents, but this is not clearly defined.

The low percentage of RNs suggests that the supervision of staff in many nursing homes is inadequate. In California, RNs only provided 20 percent of total average nursing hours, LVN/LPNs provided 17 percent of total hours, and nursing assistants provided 63 percent of total hours in 1996-97. LPN/LVN hours was 0.6 hours (36 minutes) and nursing assistant hours was 2.2 hours (132 minutes) in California in 1997-98. For nursing assistants, see Figure 11. The average ratio is one LVN for every 34 residents and one NA for every 12 residents per day. There is a wide range of staffing levels across different types of facilities with a number of facilities reporting low staffing levels. For example, 7.1 percent of the nursing facilities in California reported 1.0 to 2.4 hours per resident day and another 28.1 percent of facilities had 2.5-2.9 hours per resident day.

Setting Minimum Standards for Nurse Staffing

The average hours of care in California and the nation's nursing homes are well below what is needed for good nursing care. A recent meeting of experts on nursing home care discussed the recommendations for minimum nurse staffing standards developed by the National Citizens' Coalition for Nursing Home Reform (NCCNHR).[26] Based upon this discussion, I recommend that HCFA establish a minimum direct care ratio of nursing staff to residents in nursing homes as follows: one nursing staff person (RN, LVN/LPN or NA) for every five residents on the day shift, one nurse staff for every 10 residents on the evening shift and one nurse staff for every 15 residents at night. See Table 1. In addition, one nurse is needed at meal times to assist every 2-3 residents that need complete help with eating and one nurse is needed for every 3-5 residents that need partial assistance with eating.

Additional nurses are needed for rehabilitation and to care for residents with higher acuity levels. At the same time, one Director of Nursing with a minimum of a bachelor's degree in nursing and gerontological education is needed, one RN is needed 24 hours a day, and one RN is needed for in-service education for every 100 residents. In the long run, we should have a goal of having Directors of Nursing and registered nurses with master's degrees in gerontological nursing.

Several research studies have shown that nurse staffing levels are associated with high quality of care in nursing facilities. One of the first studies found that homes with more RN hours per resident were associated with lower mortality rates, improved physical health, and a higher rate of discharge home.[27] A number of other studies have identified the positive relationship between nurse staffing and quality of care.[28-34] Spector and Takada (1991) found that low nurse staffing levels in homes with very dependent residents was associated with reduced likelihood of improvement, high

urinary catheter use, low rates of skin care, and low rates of resident participation in organized activities.[13] Cohen and Spector (1996) found that higher ratios of registered nurses (RNs) to residents, adjusted for resident casemix, reduced the likelihood of death and that higher ratios of licensed practical nurses (LPNs) significantly improved resident functional outcomes.[35] Recently, a study of all nursing homes in the US confirmed that that higher nurse staffing levels and other staffing levels are associated with fewer deficiencies.[22] This study also found that higher staffing levels for therapists, activities staff, and dietary personnel also had a positive effect resulting in fewer deficiencies in nursing homes.[22] A recent Institute of Medicine (IOM) Committee (1996) recommended adding more registered nurse staff in nursing facilities especially an RN on duty 24 hours per day[36]

Recommendation: The current federal nursing requirements are inadequate to ensure minimum levels of nursing care. The minimum ratios of nursing staff to residents in nursing facilities should be increased to the level recommended by consumers and experts in Table 1.

Auditing and Targeting Facilities With Low Staffing

Facilities that report extremely high or low staffing should be reviewed and targeted for more frequent and for extended surveys. HCFA does not require state surveyors to review or to audit the actual staffing levels in nursing homes with quality problems as a part of the survey process nor to conduct more frequent surveys on such facilities.

Only 5.7 percent of facilities in California received deficiencies for insufficient staff in 1997-98 and yet we know from all reports that inadequate staffing is an widespread problem. This is probably because the actual staffing levels in the months before the survey are generally not reviewed and audited by surveyors. Less than one percent of facilities received citations for inadequate RN staffing, probably because the federal standard for RNs is so low that most facilities meet the requirement for one RN on duty eight hours per day for seven days per week. In addition, many facilities are reported to add more staff when a survey is occurring.

For example, one facility in California reported 1,432 staff hours per resident day compared with the average of 3.4 hours per resident. Eighteen facilities reported no staff and 30 facilities had 0.8 or less hours per resident (48 minutes) (these facilities were removed from the sample because they were assumed to be erroneous data).[c]

Figure 12 shows that 7.1 percent (74 facilities) had only 1.0 to 2.4 hours per resident day and 28 percent (294 facilities) had 2.5-2.9 hours per resident data. These data suggest that surveyors are not reviewing the nurse staffing data to determine either its accuracy or its adequacy for providing minimum levels of nursing care. All those facilities reporting staffing at less than the average levels

should be targeted for surveys and audited. Penalties are needed for failure to meet minimum staffing standards.

Recommendation: Using OSCAR data, HCFA should target those facilities with staffing levels below the average level for more frequent unannounced surveys. In those facilities where poor care is identified, staffing audits should be conducted by state surveyors using samples of actual facility payroll records. Staffing should especially be examined for weekends, evenings, nights, and holidays. Stricter penalties, including civil money penalties, should be enforced against those facilities that do not meet the minimum staffing levels and provide poor and dangerous care.

III. TARGETING QUALITY OF CARE AND LIFE VIOLATIONS

California surveyors identify many areas where nursing homes fail to meet the standards, but the most commonly cited deficiencies are not necessarily the most important quality of care areas. Figure 13 shows the top 10 most frequently cited deficiencies for poor care in California out of a total of about 185 federal standards. These include: clinical records, food sanitation, care plans, dignity, accident environment, accommodate needs, comprehensive assessments, unnecessary drugs, housekeeping, and social services.

In 1997-98, the most frequent deficiency was given for the failure to maintain appropriate clinical records on residents (42 percent). The second most frequent deficiency was for inadequate food sanitation in storing, preparing, distributing, or serving food to prevent food borne illness (40.3 percent of facilities). Of the total California facilities, 38 percent were given deficiencies for failure to prepare comprehensive resident care plans as required. In addition, 26.5 percent of facilities were given deficiencies for the failure to conduct comprehensive assessments of each resident.

Dignity was given a strong emphasis in the 1987 nursing home legislation and regulations. Thirty-seven percent of California nursing homes received deficiencies for failure to maintain the dignity of residents in 1997-98, which includes providing care for residents in a manner and in an environment that maintains or enhances dignity and respect. Another important area is accommodating individual needs. 26.5 percent of California residents were given citations for failure to accommodate the individual needs of residents in 1997-98.

The failure to maintain the environment free of accident hazards was cited in 28.4 percent of facilities. This requirement was established to prevent unexpected and unintended injury. The

prohibition against the use of unnecessary drugs was another important area emphasized in the new 1991 federal regulatory requirements. Twenty-six percent of facilities received citations for this area in California. The failure to provide adequate housekeeping (25.7 percent) was the fifth most frequently cited deficiency in 1996. This is a quality of life requirement that includes ensuring that housekeeping and maintenance services are provided to maintain a sanitary, orderly, and comfortable interior and that an adequate environment is provided for residents. Finally, 25.1 percent of facilities were cited for the failure to provide sufficient social services.

Other common deficiencies (not shown in the figure) were for poor quality of care (23.6 percent of facilities in California). Residents have the right to be free of physical restraints imposed for purposes of discipline or convenience and not required to treat the resident's medical symptoms. In 1997-98, 23.6 percent of California facilities received deficiencies for this requirement. Facilities must ensure that residents do not develop pressure sores; 22.1 percent of California facilities received deficiencies for failing to meet this standard. In summary, the California Department of Health Services is identifying many serious violations in nursing facilities.

Although these areas of the federal standards are important, other quality of care problems in nursing homes should be given more attention by surveyors. One area is incontinence care because 49 percent of residents were reported to have incontinence but only 5.9 percent of the residents were reported to be in bladder training programs. Although these problems are common, only 16.6 percent of facilities received deficiencies for the failure to provide adequate incontinence care in California (table not shown). Facilities with high percentages of bedfast residents should be targeted by surveyors, because generally residents should not be left in bed if adequate care is provided.

Poor nutritional care due to improper feeding of residents and dehydration have been reported to be common in some nursing homes. Only 11.4 percent of facilities in California were cited for problems with poor nutrition and 4.6 percent of facilities for the failure to prevent dehydration. One reason is that federal standard for weight loss of five percent in a month is not adequate to detect serious problems. The appropriate standard for identifying malnutrition should be based on low body mass and cumulative weight loss.[21] Preventable deaths and hospitalizations are critical areas to examine because they represent jeopardy to the residents. Infection control is also important to

prevent illness and death. Contractures, as noted above, are a common problem reported for 22 percent of residents.

Recommendation: HCFA should focus greater enforcement efforts on special problems areas in nursing homes such as incontinence, immobility and inactivity, poor nutrition and weight loss from time of admission, dehydration, infections, preventable deaths, preventable hospitalizations, contractures, and behavioral and emotional problems.

IV. DECLINES IN ENFORCEMENT ACTIVITIES

Nationally there has been a 42 percent decline in enforcement activities since 1991. Figure 14 shows the U.S. average number of deficiencies decreased from 8.8 deficiencies in 1991 to 5.1 per facility in 1996. California showed an increase in the average number of deficiencies per nursing facility in the 1991-1993 period. In 1993, the state averaged 17.8 deficiencies per facility but this began to decline each year until the 1997-98 period when the average number was 10.4 deficiencies.

The average number of deficiencies varied substantially across states from 1.5 per facility in Connecticut to 12.7 per facility in Nevada in 1996. California was the second highest state in the average number of deficiencies issued per facility. Even though California has a stronger record of identifying deficiencies than most other states, serious quality problems persist. This suggests that the nation's enforcement system is not working effectively.

California found 5.2 percent of its nursing facilities with no deficiencies in 1997-98. In contrast, Kentucky was the state with the highest percent of its facilities reported to have no deficiencies (56 percent in 1996). California was among the 3 states with the lowest percentage of facilities have no deficiencies, and this percentage was steady from 1991-1998. For the nation as a whole, the percent of facilities reporting no deficiencies increased from 10.8 percent in 1991 to 20.8 percent in 1996 (by 93 percent). This is another indication of reduced regulatory activities nationally.

As noted above, there are wide variations across states in the level of survey activities and deficiencies issued. The variations within states are also important. For example, data from the California State Department of Health Services showed variations across the 18 district and sub-district offices.[37] Although some variations are expected given differences in the quality of the care delivered in homes in different areas, it is clear that some of the variation is due to differences in surveyor training, activities, and/or philosophies. Variations in survey activities can be reduced by providing greater training and supervision of state survey agency staff.

Although the reasons for the decline in enforcement activities are complex, it is unlikely that the declines are because of substantial improvements in quality. The nursing home industry arguments that quality has improved are contradicted by frightening newspaper accounts of neglect and abuse from California to Detroit.[37-40] Although some nursing homes provide excellent care, there is no research literature that suggests the overall quality of nursing home care is improving. The reasons for the decline in enforcement include: (1) weak and confusing federal enforcement regulations and procedures, (2) ineffective HCFA oversight of states, (3) some states are failing to enforce the standards vigorously, (4) strong political pressures from the nursing home industry to reduce enforcement, and (5) either inadequate resources or ineffective use of resources for the regulatory process.

Toby Edelman at the National Senior Citizens Law Center argues that HCFA fundamentally reduced its enforcement effort through a series of deliberate policy actions.[41-42] These include: allowing most facilities 30-70 days to correct deficiencies (except for those that cause immediate and serious jeopardy) before imposing any penalties; imposing a moratorium on the collection of civil money penalties when the new enforcement procedures went into effect on July 1, 1995; redefining the term "widespread" to apply only to those deficiencies that affect all residents in an entire facilities (thus being overly restrictive in use of the term); creating new terms of "correction required" and "significant correction required" to avoid labeling facilities as being out of compliance with federal regulations; allowing states to avoid revisits for the lower scope and severity requirements; and encouraging states not to issue civil penalties unless they were for immediate jeopardy or poor performing facilities that had not made corrections at the time of the revisit.[41-42] The procedures HCFA established for informal dispute resolution are also problematic in causing delays and pressures for reductions in enforcement actions. These many formal and informal procedures and the many changes in the system made by HCFA created both complexity and confusion in the enforcement process. The goal of the OBRA legislation for swift action against those facilities that fail to meet the minimum federal standards is not being met. The HCFA enforcement procedures need extensive revision in order for them to be more effective.

Another explanation for the decline in enforcement activities may be that the HCFA oversight procedures that monitor states are ineffective or have had negative effects. When HCFA implemented its new enforcement standards in July 1995, it established panels of staff at the central office in Baltimore to review state enforcement procedures and asked some states to reassess their deficiencies where the staff felt the citations were not justified or not properly documented. These enforcement efforts may have directly or indirectly placed pressure on states to reduce enforcement efforts. HCFA instituted extensive training on the new resident assessment system and some training was conducted for the enforcement system. Additional training of surveyors should be undertaken to ensure greater consistency within and across states. One important issue is that states that are more

active in regulatory activities, such as California, should not have their activities reduced, but rather states should be encouraged by HCFA to take stronger enforcement actions.

Another possible explanation is that some states are not carrying out enforcement activities vigorously. Some states may have administrators who are less than supportive of regulation and enforcement, so perhaps state politics and philosophy are factors. The new enforcement process may increase the workload burdens on state survey agencies that may have detracted from the actual process of the detection of poor care.

Political pressures from the nursing home industry to reduce enforcement at both the federal and state levels are considered by many to be strong, effective, and persistent. Legal actions by the industry against the imposition of enforcement remedies have brought delays and reductions in many civil money penalties, as illustrated in California's Department of Health Services effort to impose and collect fines for deficiencies.[36]

Moreover, funds for nursing home enforcement efforts may not be sufficient at the federal and/or the state levels to conduct frequent in-depth surveys of states. Or it may be that resources need to be utilized in a more effective fashion. A comparative analysis of the resources available and the actual time and resources required to implement fully the survey and enforcement activities could address this problem as to what resources are necessary to have an effective system.

Recommendation: HCFA enforcement procedures should be streamlined to make it easier for states to identify substandard care and to enforce the federal standards in a timely fashion. Barriers to consistent and effective state and federal enforcement activities need to be removed. HCFA should impose penalties for non-compliance with standards, not just for failure to correct deficiencies.

V. CONSUMER ADVOCACY AND INFORMATION SYSTEMS

Consumer Advocacy

One important way to protect the public, in addition to the efforts of the regulatory agencies is to have active consumer organizations that advocate for nursing home residents. The California Advocates for Nursing Home Reform (CANHR) is a nonprofit consumer organization that provides consumer information services on individual nursing homes, legal information and referral services, legislative and administrative advocacy, family and social support, and counseling.[37] Each year CANHR publishes a status report on California's nursing home industry (See the appendix). CANHR

tracks all the deficiencies and enforcement against nursing homes in the state using state data and OSCAR data. They track the enforcement activities and the collection of fines and imposition of penalties. CANHR[37] in California and the National Citizen's Coalition for Nursing Home Reform (NCCNHR)[43] at the national level are vital organizations to informing, protecting, and advocating for nursing home residents. It is essential to the nursing home market place that there is an active advocacy system for consumers to counter the heavy political and legal power of the nursing home industry.

Recommendation. Consider providing public financial support for nursing home consumer advocacy organizations to ensure greater access to consumer information and consumer protection.

Information Systems

Another important way to improve quality is for HCFA to establish an information system about nursing homes. In collaboration with NCCNHR, the University of Wisconsin, and AARP, I have developed a design for summarizing the OSCAR data and making it available to consumers. This effort, funded by the Agency for Health Care Policy and Research, has demonstrated that this information can be tailored to meet the needs of consumers and that it would be encourage improvements in nursing home quality. Unfortunately, funding is not available for the information system to be implemented.

Two essential pieces of information are needed for the information system that are not currently available on OSCAR. One is information on corporate ownership that can be used to track nursing home owners with poor compliance records. Current OSCAR data only show the names of the facilities but not the owners. Enforcement actions against facilities are also not included on OSCAR unless the facility's certification is terminated. Such data would need to be added to OSCAR to make the system more comprehensive.

Recommendation: A consumer information system using OSCAR data should be funded so that HCFA could place the data on the Internet. This information system should include OSCAR data on all facilities in the country in a readily accessible format, including: (1) facility characteristics; (2) resident characteristics; (3) staffing; (4) deficiencies including the scope and severity of deficiencies; and (5) complaints. In addition, HCFA needs to collect and make data on corporate ownership and enforcement actions against individual nursing facilities available to consumers. The information system should include data for the past three years to identify patterns of noncompliance with regulations over time.

SUMMARY AND DISCUSSION

Much progress has been made in identifying the critical elements of quality of care and quality of life for people in nursing facilities. The quality problems in some nursing homes continue to be poor and to fall well below the federal standards. Although OBRA 1987 legislation creates a strong basis for an effective regulatory system, the trends in reduced levels of enforcement observed in California and the nation are very troubling. We need a commitment to strong enforcement. More work is needed to improve the survey and enforcement system to improve quality of care. Targeted review of facilities with high frequencies of resident problems and low staffing should be implemented. Clearer guidelines for surveyors to assist them in identifying inadequate quality of care and taking effective and consistent enforcement actions are needed. Public support for nursing home consumer advocacy organizations and for a HCFA nursing home information system for consumers is also critical.

REFERENCES

1. Harrington, C., H. Carrillo, S. Thollaug, and P. Summers 1997. *Nursing Facilities, Staffing, Residents, and Facility Deficiencies, 1991-96.* Report Prepared for the Health Care Financing Administration. San Francisco, CA: University of California.

2. Palmer, M.H., German, P.S., & Ouslander, J.G. (1991). Risk Factors for Urinary Incontinence One Year After Nursing Home Admission. Research in Nursing & Health, 14:405-412.

3. Palmer, M.H., Bennett, R.G., Marks, J., McCormick, K.A. and Engel, B.T. (1994). Urinary Incontinence: A Program that Works. Journal of Long Term Care Administration. Summer: 19-25.

4. Ouslander, J.G., Buxton, W.G., Al-Samarrai, N.R., Cruise, P.A., Alessi, C., and Schnelle, J.F. (1998). Nighttime Urinary Incontinence and Sleep Disruption Among Nursing Home Residents. J. of American Geriatrics Society. 46 (4):463-6.

5. Schnelle, J.F., MacRae, P.G., Ouslander, J.G., Simmons, S.F., Nitta, M. (1995). Functional Incidental Training, Mobility Performance, and Incontinence Care With Nursing Home Residents. J. of the American Geriatrics Society. 43 (12):1356-62.

6. Schnelle, J.F., Keeler, E., Hays, R.D., Simmons, S., Ouslander, J.G., Siu, A.L. (1995). A Cost and Value Analysis of Two Interventions With Incontinent Nursing Home Residents. J. of the American Geriatrics Society. 43 (10):1112-7.

7. Evans, L. and Strumpf, N. (1989). Tying Down the Elderly. Journal of the American Geriatrics Society. 37:65-74.

8. Libow, L. and Starer, P. (1989). Care of the Nursing Home Patient. New England Journal of Medicine. 321:93-96.

9. Burton, L.C., German, P.S., Rovner, B.W., Brant, L.J., and Clark, R.D. (1992). Mental Illness and the Use of Restraints in Nursing Homes. The Gerontologist. 32 (2):164-170.

10. Phillips, C.D., Hawes, C., and Fries, B.E. (1993). Reducing the Use of Physical Restraints in Nursing Homes: Will it Increase Costs? American Journal of Public Health. 83 (3):342-348.

11. Zimmerman, D.R., Karon, S.L., Arling, G. et al. (1995). Development and Testing of Nursing Home Quality Indicators. Health Care Financing Review. 16 (4):107-127.

12. Mukamel, D.B. (1997). Risk-Adjusted Outcome Measures and Quality of Care in Nursing Homes. Medical Care. 35 (4):367-385.

13. Spector, W.D. and Takada, H.A. (1991). Characteristics of Nursing Homes That Affect Resident Outcomes. Journal of Aging and Health. 3 (4):427-454.

14. Ribeiro, B. and S. Smith. 1985. Evaluation of Urinary Catheterization and Urinary Incontinence in a General Nursing Home Population. *Journal of the American Geriatrics Society* 33:479-481.

15. Fries, B.E., Schneider, D., Foley, M., Gavazzi, M., Burke, R., Cornelius, E. (1994). Refining a Case-mix Measure for Nursing Homes: Resource Utilization Groups (RUGS-III). Medical Care. 32 (7):668-685.

16. Harrington, C., C. Tompkins, M. Curtis, and L. Grant. 1992. Psychotropic Drug Use in Long Term Care Facilities: A Review of the Literature. *The Gerontologist* 32 (6): 822-833.

17. Kayser-Jones, J. and Schell, E. (1997). The Effect of Staffing on the Quality of Care at Mealtime. Nursing Outlook. 45 (2):64-72.

18. Kayser-Jones, J., Schell, E., Porter, C., and Paul, S. (1997). Reliability of Percentage Figures Used to Record the Dietary Intake of Nursing Home Residents. Nursing Home Medicine. 5 (3):69-76.

19. Kayser-Jones, J., (1996). The Importance of Mealtime in Nursing Homes. J. of Gerontological Nursing. 22 (3):26-31.

20. Warren, J.L., Bacon, E., Harris, T., McBean, A.M., Foley, D., and Phillips, C. (1994). The Burden and Outcomes Associated with Dehydration Among US Elderly, 1991. American Journal of Public Health. 84 (8):1265-1269.

21. Blaum, C.S., Fries, B.E., and Fiatarone, M.A. (1995). Factors Associated with Low Body Mass Index and Weight Loss in Nursing Home Residents. Journal of Gerontology. 50A(3):M162-M168.

22. Zimmerman, D.R., Karon, S.L., Arling, G. et al. (1995). Development and Testing of Nursing Home Quality Indicators. Health Care Financing Review. 16 (4):107-127.

23. Harrington, C., Zimmerman, D., Karon, S.L., Robinson, J., and Beutel, P. (1998). Nursing Home Staffing and Its Relationship to Deficiencies. San Francisco, CA: University of California.

24. Harrington, C., Carrillo, H., Mullan, J. and Swan, J.H. (1998). Nursing Facility Staffing in the States: 1991-1995. Medical Care Research and Review. In press.

25. Harrington, C., Mullan, J., Carrillo, H. (1998). Predictors of Nursing Facility Staffing in the U.S. San Francisco, CA: University of California.

26. John A. Hartford Foundation Institute for Geriatric Nursing (April 1998). Staffing, Casemix and Quality in Nursing Homes. An Invitational Conference. New York, NY: New York University, Division of Nursing.

27. Linn, M, L. Gurel, and B.A. Linn. 1977. Patient Outcome as a Measure of Quality of Nursing Home Care. *American Journal of Public Health* 67, 337-344.

28. Nyman, J.A. 1988. The Effect of Competition on Nursing Home Expenditures Under Prospective Reimbursement. *Health Services Research* 23:555.

29. Gustafson, D.H., F.C. Sainfort, R.Van Konigsveld, and D.R. Zimmerman. 1990. The Quality Assessment Index (QAI) for Measuring Nursing Home Quality. *Health Services Research* 25 (1):97-127.

30. Nyman, J.A. 1988. Improving the Quality of Nursing Home Outcomes: Are Adequacy- or Incentive-Oriented Policies More Effective. *Medical Care* 26:1158-1171.

31. Munroe, D.J. 1990. The Influence of Registered Nursing Staffing on the Quality of Nursing Home Care. *Research in Nursing and Health* 13 (4):263-270.

32. Cherry, R.L. 1991. Agents of Nursing Home Quality of Care: Ombudsmen and Staff Ratios Revisited. *The Gerontologist* 21 (2):302-308.

33. Aaronson, W.E., J.S. Zinn, M.D Rosko. 1994. Do For-Profit and not-For-Profit Nursing Homes Behave Differently? *The Gerontologist* 34 (6):775-786.

34. Ramsay, J.D., F. Sainfort, and D. Zimmerman. 1995. An Empirical test of the Structure, Process, and Outcome Quality Paradigm Using Resident-Based, Nursing Facility Assessment Data. *American Journal of Medical Quality* 10 (2):63-75.

35. Cohen, J.W. and W.D. Spector. 1996. The Effect of Medicaid Reimbursement on Quality of Care in Nursing Homes. *Journal of Health Economics* 15:23-28.

36. Institute of Medicine (IOM). 1996. Committee on the Adequacy of Nurse Staffing in Hospitals and Nursing Homes. *Nursing Staff in Hospitals and Nursing Homes: Is It Adequate?*. Washington, DC: National Academy Press.

37. California Advocates for Nursing Home Reform (1998). Status Report on California Nursing Homes for 1996-97. San Francisco, CA: California Advocates for Nursing Home Reform.

38. Rarick, E. (1995) Dignity in Distress: State's Nursing Homes Not Always the Rock of Aged. Contra Costa Times. September 24, 1995, 1A, 4A-7a.

39. Kauffman, C. (1996). Abuse & Neglect: An Investigative Report on Quad-City Nursing Homes. Quad-City Times. Series. December 1, 1996 through December 8, 1996.

40. Young, A. (1996) Who Cares? Inside Michigan's Nursing Homes. Detroit Free Press. October 7, 1996, 6A-9A. October 8, 1996, 5A-7A, October 9, 1996, 8A-9A. October 10, 1996, 7A-9a. October 11, 1996, 1A, 1A-1S-8S.

41. Edelman, T. (1997). An Unpromising Picture: Implementation of Reform Law's Enforcement Provisions Troubles Advocates. Quality Care Advocate. March, 1997.

42. Edelman, T. (1998). What Happened To Enforcement? Nursing Home Law Letter. Washington, D.C.: National Senior Citizens Law Center. No. 1-2, February 13, 1998.

43. National Citizens' Coalition for Nursing Home Reform. (1997). White House Overturns Proposal to Narrow Nursing Home Surveys. Quality Care Advocate. December/January 1997, 1.

FOOTNOTES

a METHODS

This study reports on the status of California nursing homes using data from the federal On-Line Survey, Certification and Reporting System (OSCAR). The report uses data from Harrington, C., H. Carrillo, S. Thollaug, and P. Summers, 1997. *Nursing Facilities, Staffing, Residents, and Facility Deficiencies, 1991-96.* Report prepared for the Health Care Financing Administration. San Francisco, CA: University of California. In addition, it adds new data from OSCAR for January 1997 through May 1998. Data for the US for 1997-1998 have not yet been examined because of incomplete data for all facilities due to the six-month time lag in completed OSCAR data.

This is the first report of historical trend data for 1991-1998 on resident characteristics and problems, staffing, and deficiency patterns for nursing facilities since passage of the Nursing Home Reform Act of 1987. OSCAR data are HCFA administrative records and are the only source of comprehensive information about facilities, staffing, and deficiencies based on the evaluations of surveyors for the U.S. and for states.

All nursing facilities federally certified for Medicare (skilled nursing care) and Medicaid (nursing facilities) in the 50 states and the District of Columbia are on the database. These data are from the regular federal surveys conducted by state survey agencies about every 9 to 15 months. The OSCAR data has three separate data files: (1) health facility survey file (with facility resident characteristics); (2) staffing data; and the (3) health survey deficiencies which includes the scope and severity data. OSCAR data on resident characteristics are completed on standardized forms by individual nursing homes at the beginning of each survey. OSCAR deficiency data are recorded by state surveyors after they determine whether the facility has met or not met each standard.

Detailed edit procedures were developed by the authors to ensure that the OSCAR data were as accurate as possible and data were arranged by calendar year. This process included eliminating any duplicate provider records by matching on the facility name, address and telephone number. The total numbers of beds and residents were cleaned by removing erroneous data and extreme outliers. HCFA reports approximately 16,500 certified nursing homes in the U.S. in 1996. As a result of the cleaning process which eliminated 370 duplicate records and 530 facilities with survey dates outside the calendar year, the data reported were for about 15,600 facilities surveyed in calendar year 1996 at the time of the survey.

b FACILITY CHARACTERISTICS

In California, the average facility occupancy rate was only 82.9 percent (or slightly below the national average of 85 percent in 1996). In the total facilities, 26 percent of residents were paid for by private sources, 9 percent by Medicare, and the remainder by Medicaid (65 percent). In California, 74 percent of facilities are owned by for-profit organizations, (compared with 66 percent nationally), while 22 percent are not-for-profit, and 4 percent are publicly owned. Sixty percent of the state's nursing homes are owned by chain organizations and 19 percent are hospital based.

c RESIDENT CHARACTERISTICS AND PROBLEMS

Facilities categorized all their residents on each of three activities of daily living. A score of 1 was assigned to the most independent residents, 2 for moderate dependency, and a 3 for completely dependency, and then the average score for all residents in each facility was computed. A summary score for the three ADLs was computed and divided by three for three-point scale in the 1994-96 period. Because the data for the 1991-1993 period used a five point scale, the same approach was used but the summary score was divided by five to obtain the average.

d STAFFING

Since the OSCAR data were reported in fulltime equivalents (FTEs) for a 14 day period, the staffing data were converted to staffing hours per resident day. To make this conversion, the total nurse staff payroll FTEs reported for a two week period were multiplied by 70 hours for the period and then divided by the total number of residents and by 14 days in the reporting period (this is the conversion procedure used by HCFA). All nursing staff were added together (including fulltime, parttime, and contract staff) by category of staff.

An examination of the staffing data showed that some facilities reported very high or very low levels of staffing. In order to minimize the number of facilities that may have reported erroneous data, we developed standard rules to remove these facilities from the data set. Where a facility reported either no nurses or no residents, the facility was eliminated from the study. Some facilities reported extremely high numbers of staff per resident day which appeared to be inaccurate. The staffing data showed a number of outliers that resulted in skewed distribution for each of the categories (skewness statistics ranging from 2.18 to 3.31). After examining the distribution of staffing hours per resident day, a judgment was made by the investigators to eliminate facilities with staffing levels in the lower one percent of facilities and the upper 2 percent of facilities within in each staffing category. This procedure eliminated 3 percent of the total sample by removing those outliers (about 500 facilities) which appeared likely to be erroneous in the US. All facilities with less than 16 beds were dropped from the analysis because they were not typical of other facilities. As a result of the cleaning process, the OSCAR data included about 12,400 facilities surveyed in the calendar year 1996. For California, 18 facilities were dropped because they reported zero hours of nursing staff and 90 facilities were dropped because they had less than 16 beds. The top 2 percent of facilities with high staffing levels (with 18.8 hours per resident day or more) were dropped (160 facilities) and those facilities with 0-0.8 hours per resident day were dropped (30 facilities).

Finding Summaries and Recommendations

Excerpted From a Draft Version of California Advocates for Nursing Home Reform's 1996-97 *Status Report On California's Nursing Home Industry*.

QUALITY OF CARE

In 1996, California's nursing homes received a total of 23,929 deficiencies for failing to meet minimum standards of care. In 1997, California facilities averaged 10.38 deficiencies per facility (a total of 23,485), compared to a national average of 4.78 deficiencies per facility during the same period. California led the nation in 1997 in deficiencies for failing to complete a comprehensive care plan for residents, with over 41% of facilities receiving deficiencies. During the calendar years 1996 and 1997, 1,516 state citations were issued for violations of regulations and $4.549 million in fines were assessed. Documented violations resulted in 28 deaths as a direct result of these violations, and another 94 deaths as an indirect result.

RECOMMENDATIONS

- California's flat rate Medi-Cal reimbursement needs to be replaced by a cost component system that encourages quality care, provides incentives for facilities to pay higher wages for direct care staff and promotes greater accountability of public dollars.
- The development of community-based, not for profit nursing homes should be encouraged through legislative, policy and economic incentives.
- California needs to develop a comprehensive, coordinated and regulated long term care system that promotes community based and in-home care with appropriate Medicaid waivers.

STAFFING

California nursing homes continue to be short staffed, relying on an antiquated formula that ensures legal compliance, but has no basis in reality. With no mandated staff to patient ratio and no uniform training, understaffing and untrained staff continue to be the biggest factors in inadequate patient care. While Nursing Assistants comprise the largest part (68.2%) of the direct care hours in California's nursing homes, their wages comprise less than 47% of the total salaries for direct care. The hourly average wage rate for nursing assistants was $6.99 as of 12/31/96.This represents a total of less than a 5% wage increase in all of 1995 and 1996.

RECOMMENDATIONS

- A staff to patient ratio based on case mix should be adopted in California, with the elimination of the doubling of certified nursing hours.
- In the absence of complete rate restructuring, any future rate increases to California's nursing homes should include a wage pass through to improve salaries and benefits for nursing home workers.
- Standard, uniform training at state-approved institutions should be mandatory for all CNAs prior to employment, with an increase in the number of hours of classroom and hands-on training required prior to certification.
- Educational incentive programs with tuition credits for work should be instituted in California's Community Colleges to provide support for career advancement of Certified Nurses Aides

RESIDENTS' RIGHTS/RESTRAINTS

In 1997, 38% of California's nursing homes were cited for failing to provide care which enhances dignity - almost three times the national average of 13%; 27.74% were cited for violating residents' rights to reasonable accommodations of individual needs; and 15% for violating residents' rights to privacy. 306 California nursing homes received citations for verbal, physical or sexual abuse and many more were cited for violations of residents' rights. Chemical restraint use jumped 17% during 1996 and 1997.

RECOMMENDATIONS

- Health & Safety Code §1430(b) should be amended to allow unlimited damages to residents who are the victims of residents' rights violations.
- As a condition of licensing, all facilities should be required to install a "wanderer alert" system, and a restraint reduction program should be mandatory in all facilities.
- Violation of the informed consent regulations should be cited as an automatic Class A citation, with appropriate remedies assessed.

ENFORCEMENT

The number of citations issued against facilities decreased 31% in 1996 to 766, with a decrease to 750 in 1997. Over 71% of the citations issued were Class B, and over 60% of these had the fines waived. Only 23% of the $5,095,275 in fines assessed in 1996 & 1997 were collected, and over 41% of the fines were waived, reduced or dismissed.

Under the federal enforcement system implemented in 1996, 72 facilities received fines ranging from $500 to $10,000 per day. An additional 9 facilities were put on fast track terminations and 17 were involuntarily decertified from the Medicare/Medicaid programs.

RECOMMENDATIONS

- Data on resident characteristics, such as high restraint use, should be used to target facilities for focused enforcement.
- The Department needs to make full use of the variety of enforcement remedies available under state and federal laws prior to final decertification from the Medicare/ Medicaid programs, including directed plans of correction, bans on admission and temporary managers in cases of revocation.
- The Department should make greater use of Medi-Cal offset to collect outstanding fines and penalties.
- The Department should support legislative and regulatory changes necessary to hold nursing facility owners, managers and licensees responsible for reimbursement of costs incurred for enforcement activities such as receiverships and/or relocation.
- Complaint investigations should focus on timeliness, consistency among district offices, adequacy of investigations and follow-up.
- Ownership disclosure and suitability of ownership requirements need to be revised to reflect true ownership, conflicts of interest, compliance history and fiscal ability. A centralized ownership data base needs to be established to track compliance history among chains and timely changes of ownership.
- DHS's Licensing & Certification should develop a comprehensive performance ranking system of all facilities and a system of early intervention designed to bring facilities into compliance rather than close facilities.
- The lack of consistency in enforcement activities among the District Offices should be addressed, with special emphasis on the inconsistency in enforcement remedies imposed, conflicts of interest and the fact that facilities have advanced knowledge of "unannounced" surveys.

ACCOUNTABILITY

The State of California spent $4.026 billion on skilled nursing facility care during calendar years 1996 & 1997, with little or no accountability for how this money was spent. The lack of leadership from the Governor and the Attorney General's Office has left residents vulnerable to abuse, neglect and transfer trauma. Of the 515 neglect cases closed by the Attorney General's Office in 1996, only 10 resulted in convictions. CAHF, the for-profit nursing home association, spent $728,001 in 1996 on lobbyists and campaign contributions.

RECOMMENDATIONS

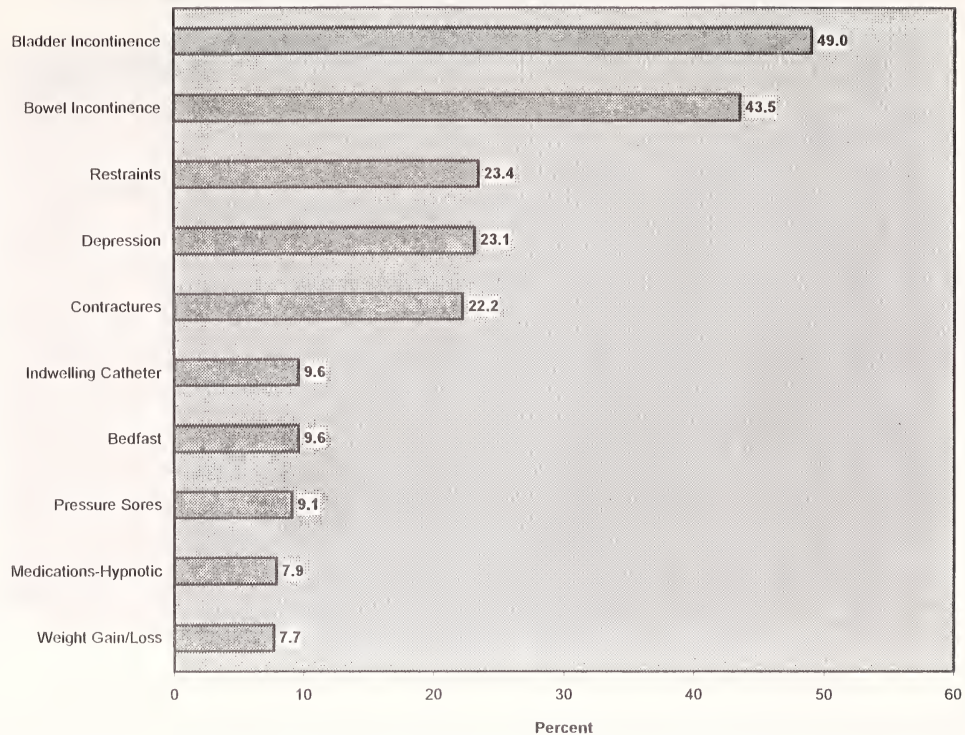
- California's audit system for nursing facilities should be overhauled to audit nursing home chains as a group, increase the number of audits to 33% per year, detect and report fraudulent reporting and enhance recovery practices.
- The Attorney General's Medi-Cal Fraud and Patient Abuse Unit should be evaluated, with specific recommendations for improvement in investigation and prosecution of Medi-Cal fraud and patient abuse. The Unit should coordinate activities with the Licensing & Certification and with the Audits and Investigations sections of DHS. Public reports on activities of the Unit should be published annually.
- Finally, we need policy makers and legislators with the courage to fend off assaults from the nursing home industry, reject their financial contributions and declare war on abuse and neglect in our nursing homes.



California Advocates for Nursing Home Reform
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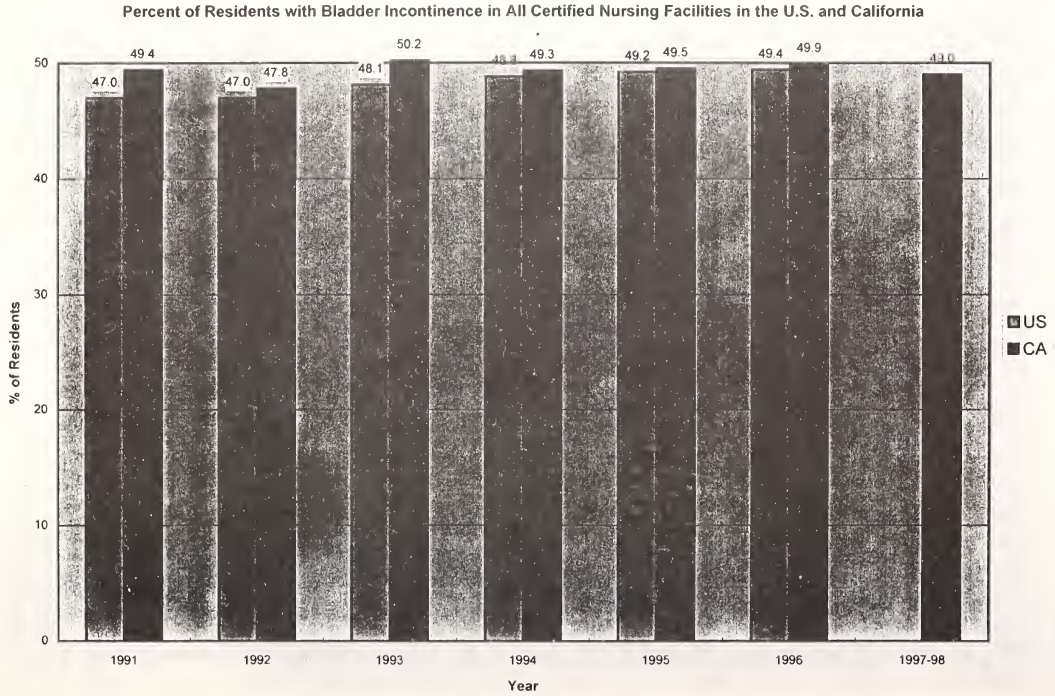
Figure 1

Percent of Resident Characteristics in all Certified Nursing Facilities in California for the Period January 1997 - May 1998 (N=1345)



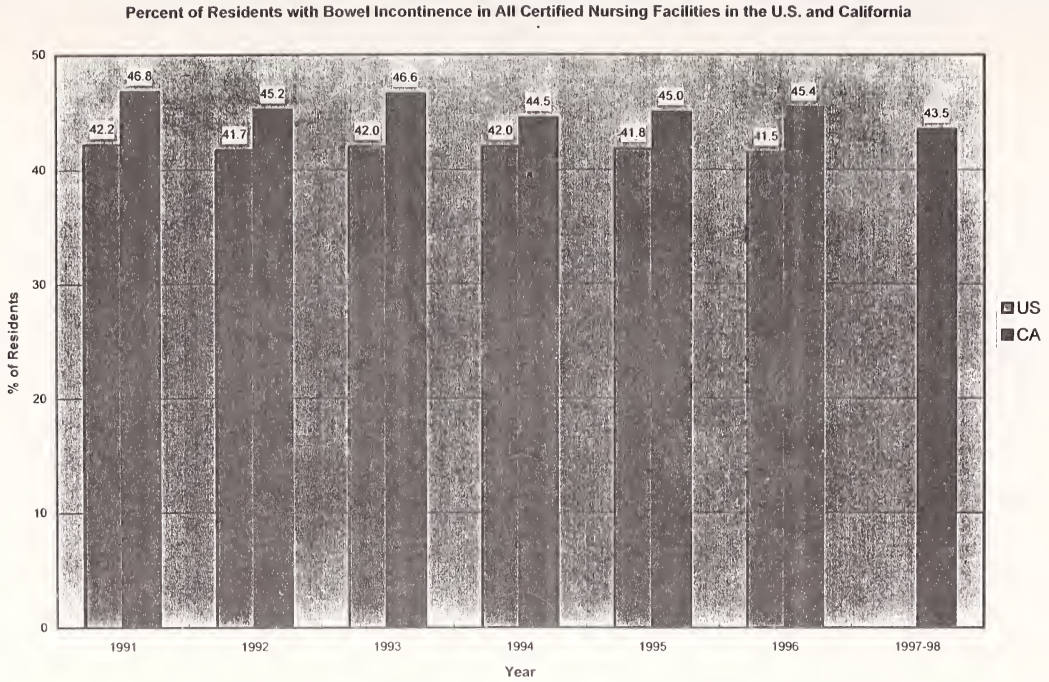
Source: HCFA On-Line, Certification and Reporting System, Health Care Financing Administration. Prepared by C. Harrington and H. Carrillo, University of California, San Francisco.

Figure 2



Source: On-line Survey Certification and Reporting Data, Health Care Financing Administration. Prepared by C. Harrington and H. Carrillo, University of California, San Francisco.

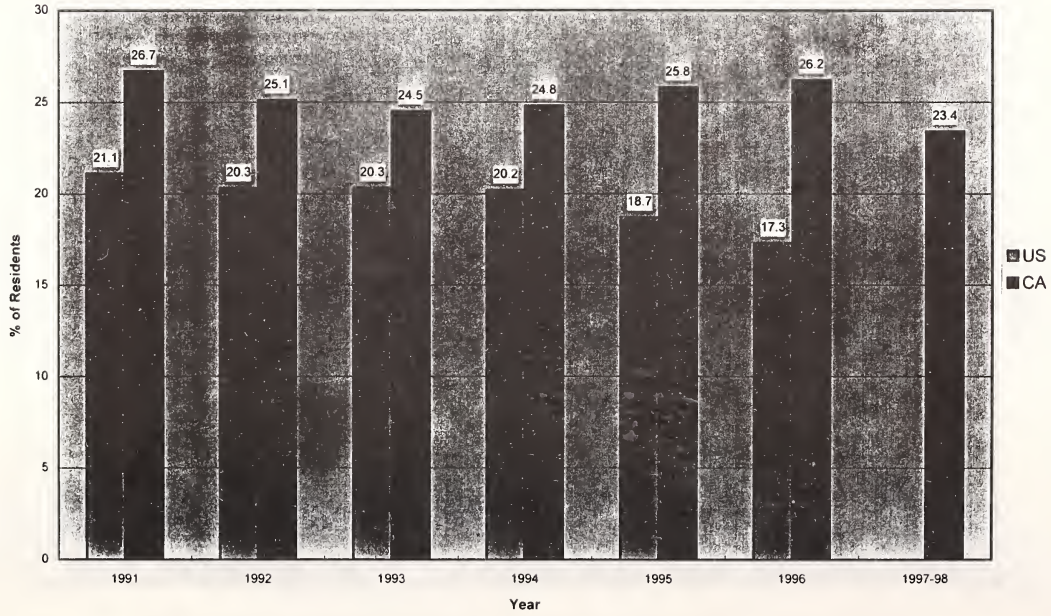
Figure 3



Source: On-line Survey Certification and Reporting Data, Health Care Financing Administration. Prepared by C. Harrington and H. Carrillo, University of California, San Francisco.

Figure 4

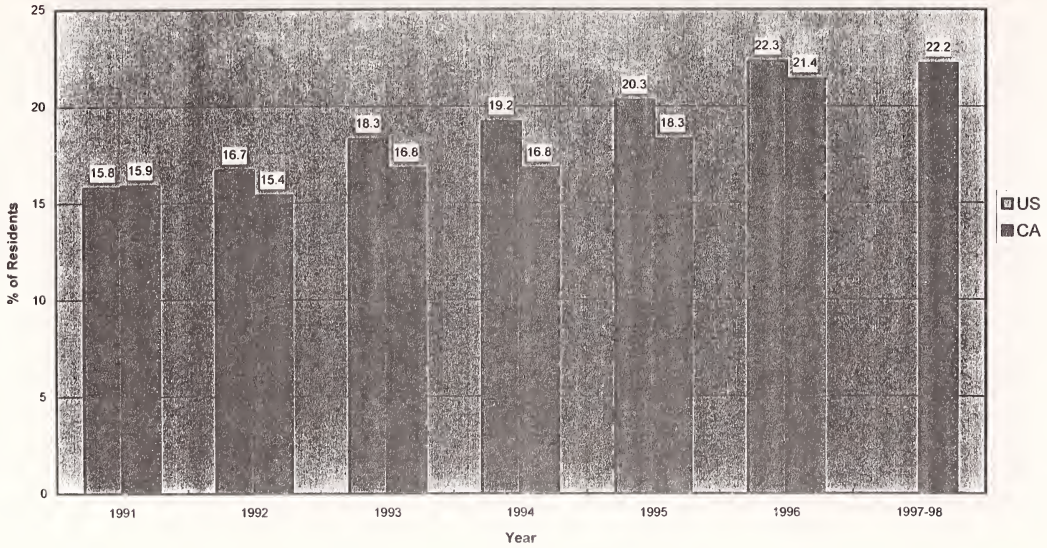
Percent of Residents with Physical Retraints in All Certified Nursing Facilities in the U.S. and California



Source: On-line Survey Certification and Reporting Data, Health Care Financing Administration. Prepared by C. Harrington and H.Carrillo, University of Cal[illegible]nia, San Francisco.

Figure 5

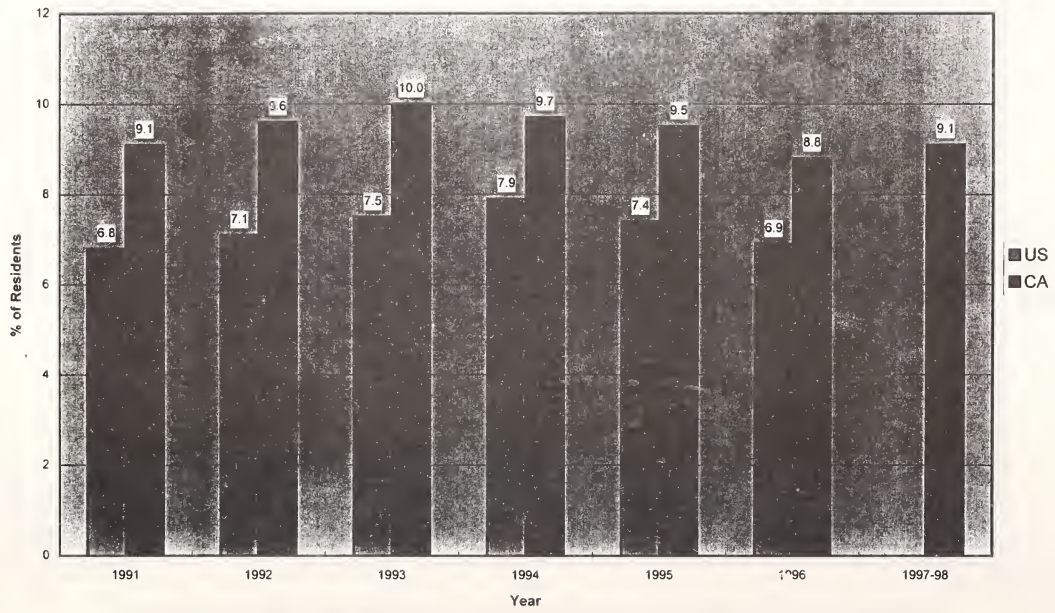
Percent of Residents with Contractures in All Certified Nursing Facilities in the U.S. and California



Source: On-line Survey Certification and Reporting Data, Health Care Financing Administration. Prepared by C. Harrington and H. Carrillo, University of California, San Francisco.

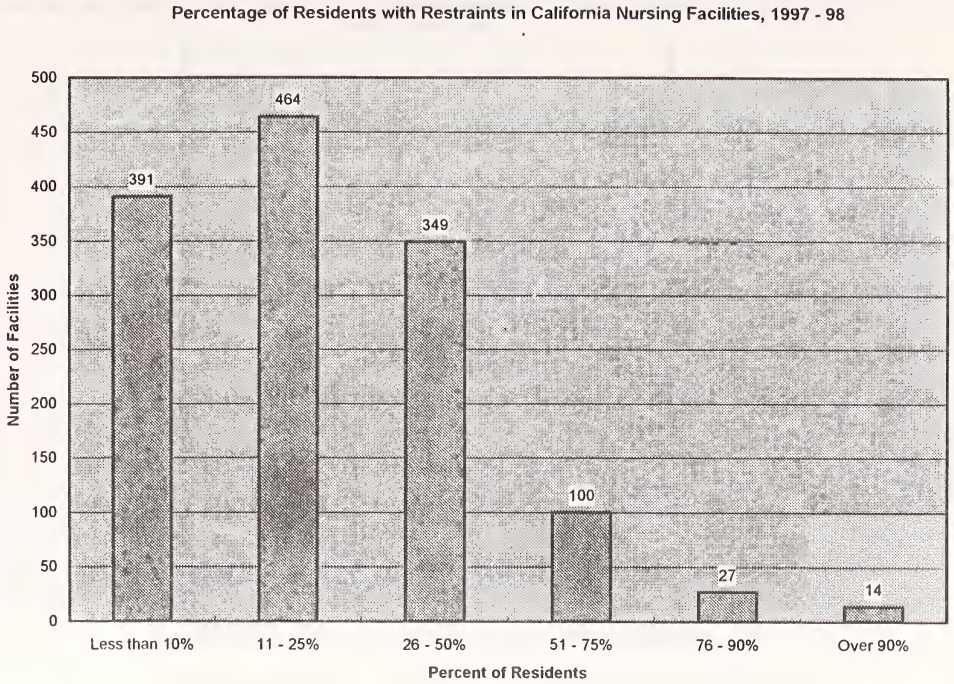
Figure 6

Percent of Residents with Pressure Sores in All Certified Nursing Facilities in the U.S. and California



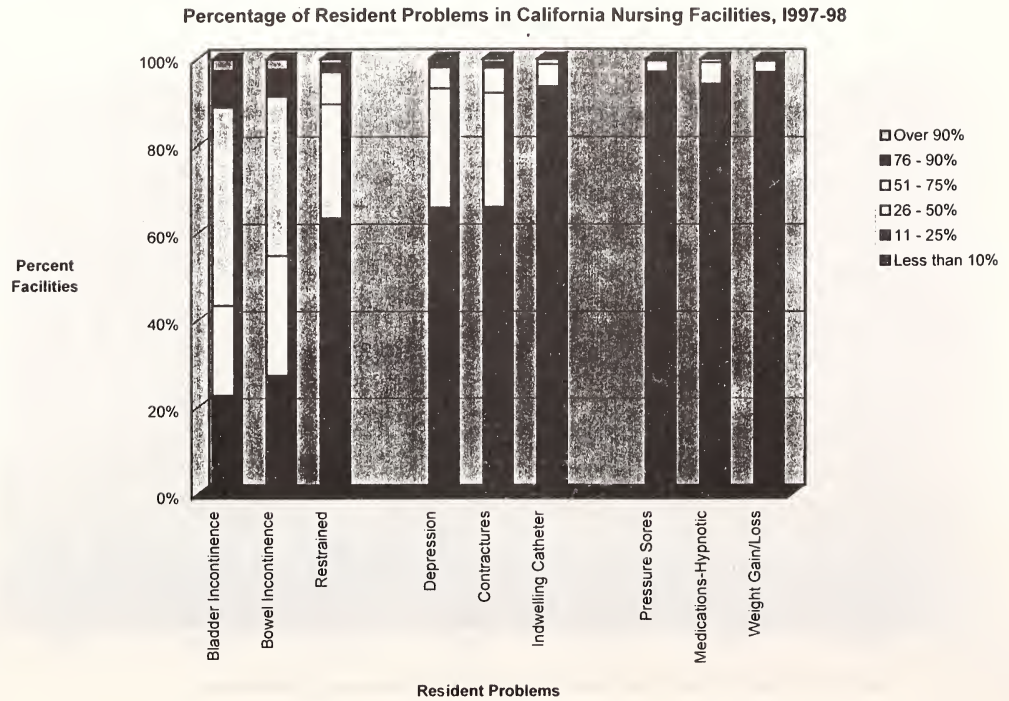
Source: On-line Survey Certification and Reporting Data, Health Care Financing Administration. Prepared by C. Harrington and H. Carrillo, University of Cali[illegible]nia, San Francisco.

Figure 7



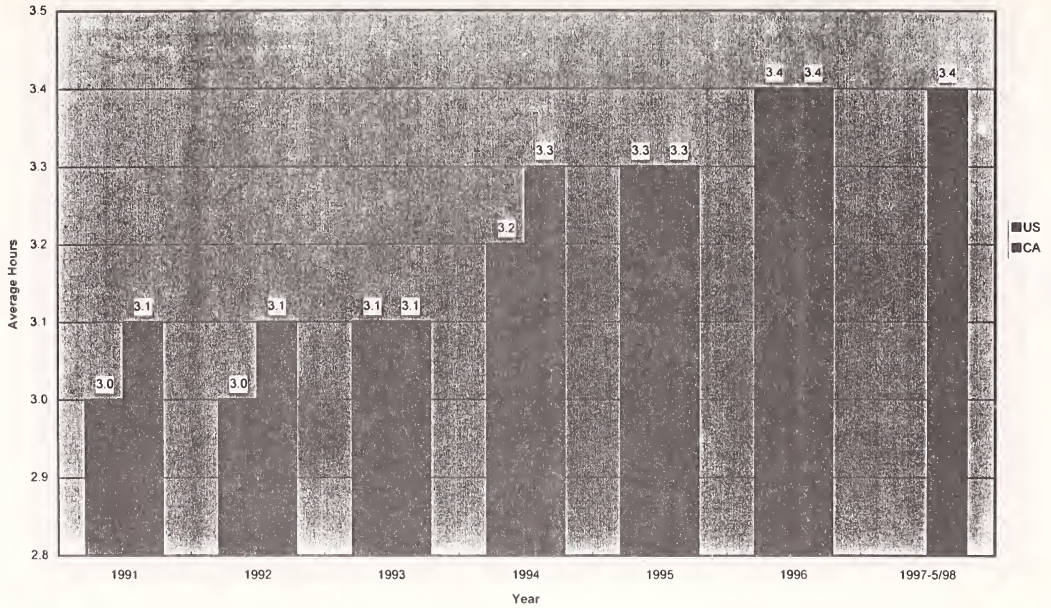
Source: On-Line Survey Certification and Reporting System, Health Care Financing Administration. Prepared by C. Harrington and H. Carrillo, University of California, San Francisco, CA.

Figure 8



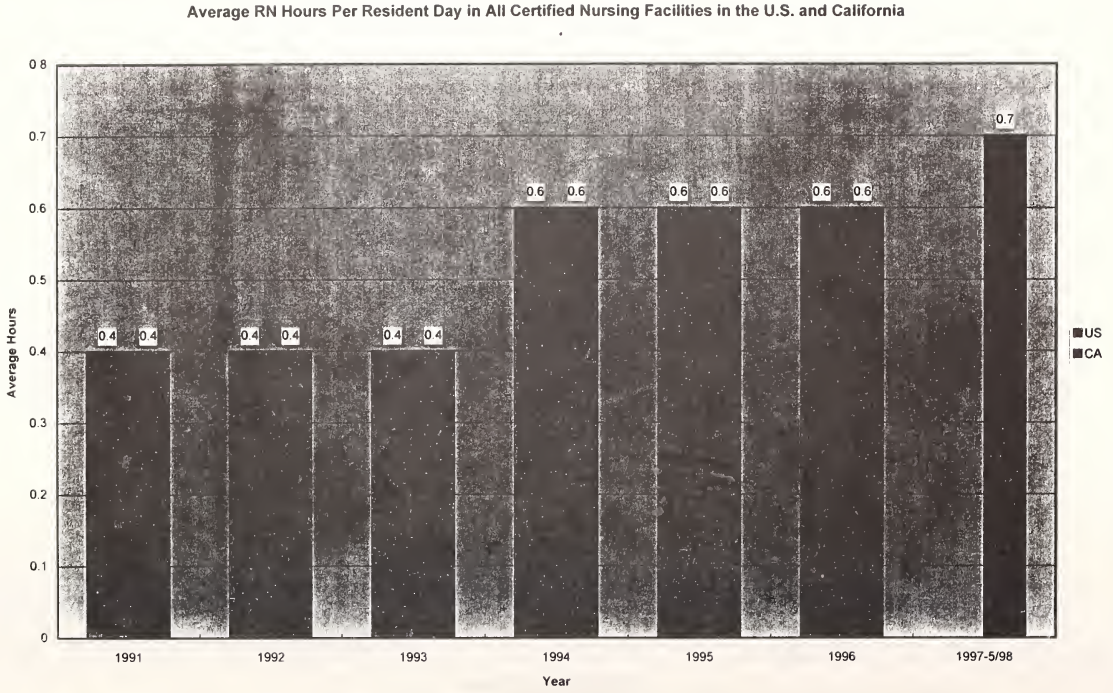
Source: On-Line Survey Certification and Reporting System, Health Care Financing Administration, January 1997 through May 1998. Prepared by C. Harrington and H. Carrillo, University of California San Francisco, CA.

Average Combined Nurse Hours (RNs, LVN/LPNs, and NAs) Per Resident Day in All Certified Nursing Facilities in the U.S. and California

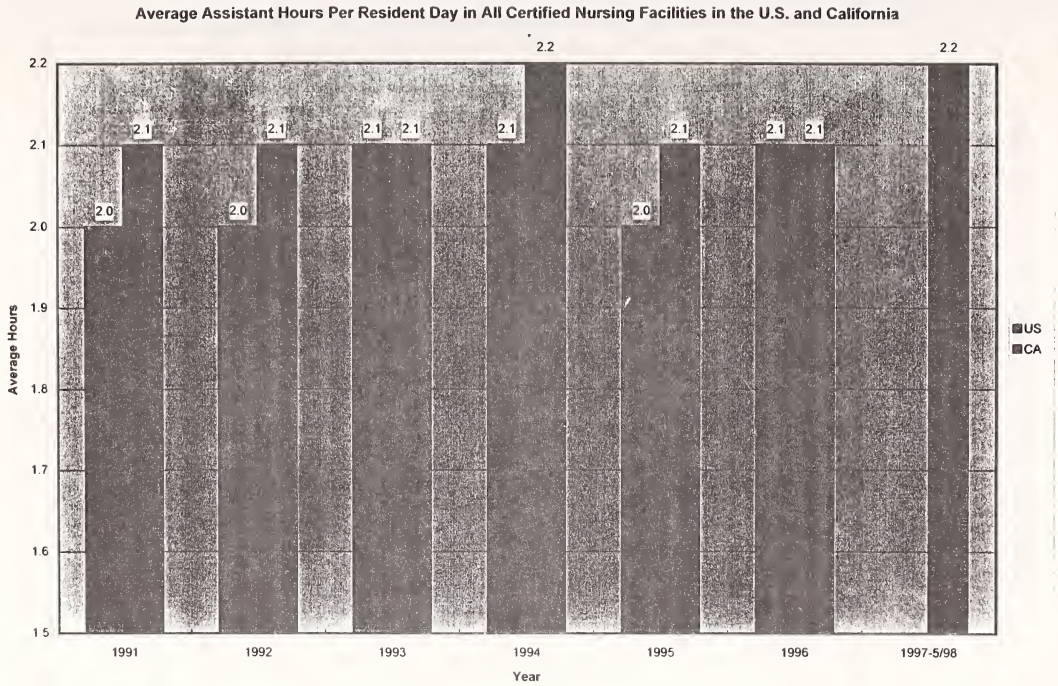


Source: On-Line Survey Certification and Reporting System, Health Care Financing Administration. Prepared by C. Harrington and H. Carrillo, University of California San Francisco, CA.

Figure 10



Source: On-Line Survey Certification and Reporting System, Health Care Financing Administration. Prepared by C. Harrington and H. Carrillo, University of California, San Francisco, CA.



Source: On-Line Survey Certification and Reporting System, Health Care Financing Administration. Prepared by C. Harrington and H. Carrillo, University of California, San Francisco, CA.

Table 1

PROPOSED MINIMUM STAFFING STANDARDS

FOR NURSING HOMES*

Administration Standard

A full-time RN Director of Nursing with a Bachelor's Degree and Gerontology training
(allow for grandfathering of current RN Directors for a limited period)
A part-time RN Assistant Director of Nursing (full-time in facilities of 100 beds or more)
A part-time RN Director of In-Service Education with Gerontology training
(full-time in facilities of 100 or more)
A full-time RN nursing supervisor on duty at all times (24 hours per day, 7 days per week)

A ratio of Direct Care Givers (RNs, LPNs/LVNs, and CNAs) to residents
(excluding nursing administrators):

Day Shift	1 FTE: 5 Residents
Evening Shift	1 FTE:10 Residents
Night Shift	1 FTE:15 Residents

And a ratio of Licensed Nurses (RNs. LPNs/LVNs) to residents:

Day Shift	1 FTE:15 Residents
Evening Shift	1 FTE:25 Residents
Night Shift	1 FTE:35 Residents

And, in addition, at all mealtimes, there will be:

1 FTE : 2-3 Residents who are entirely dependent on assistance.
1 FTE : 3-5 Residents who are partially dependent on assistance

Staffing must be ADJUSTED UPWARD for residents to take into account casemix:
(For example, residents with extensive nursing or rehabitation needs require higher care than average staffing)

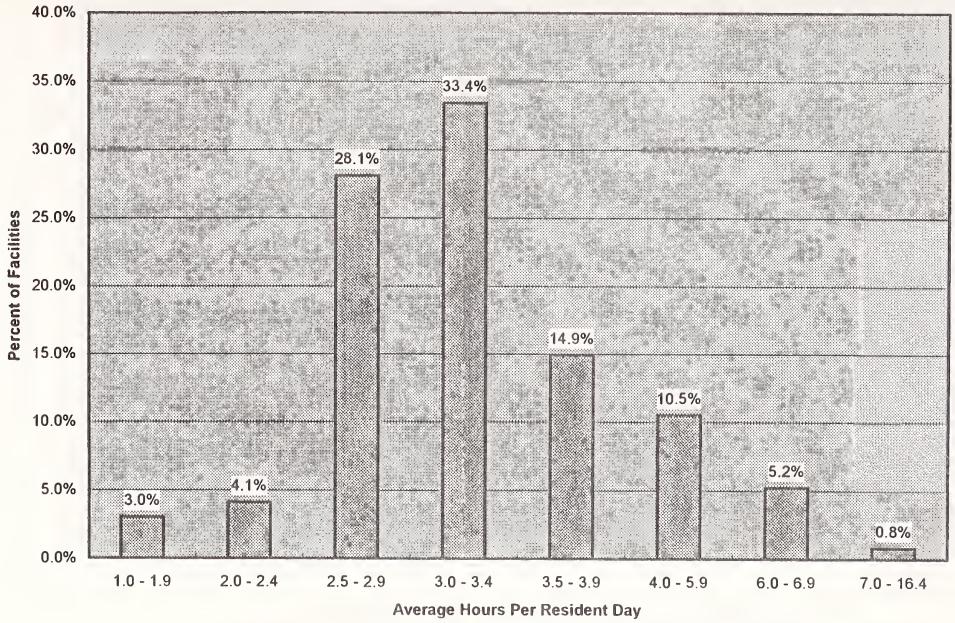
Each nursing home is strongly urged to have a part-time Geriatric or Adult Nurse Practitioner and/or a Geriatric Clinical Nurse Specialist on staff (full-time for 100 beds or more).

No staffing waivers should be allowed.

* Builds on the Nurse Staffing Standards developed by the National Citizen's Coalition for Nursing Home Reform, Washington, D.C.

Figure 12

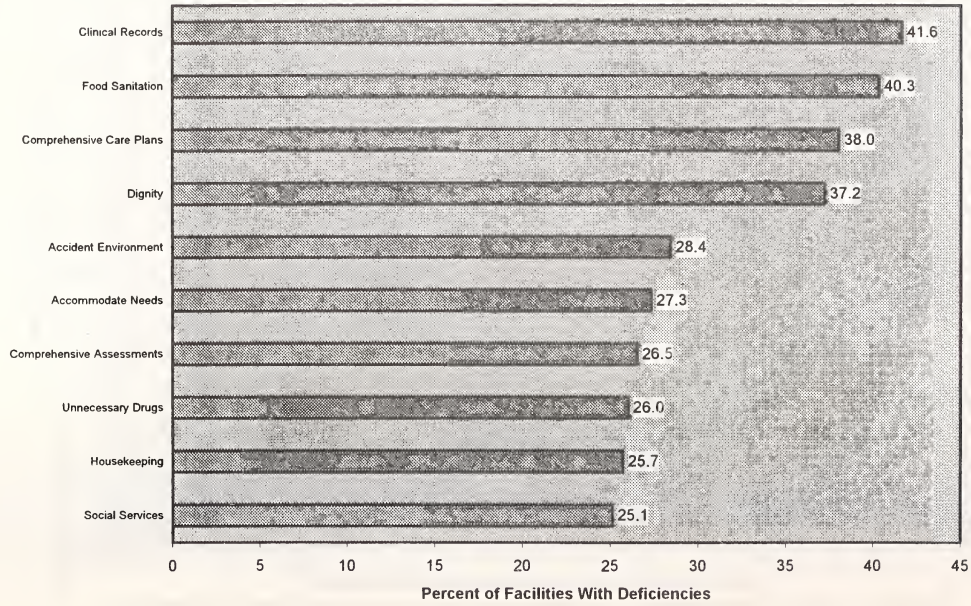
Distribution of Combined Nurse Hours Per Resident Day in all Certified Nursing Facilities in California During the Period January 1997 - May 1998 (N=1,045)



Source: On-Line Survey Certification and Reporting System, Health Care Financing Administration. Prepared by C. Harrington and H. Carrillo, University of California, San Francisco, CA.

Figure 13

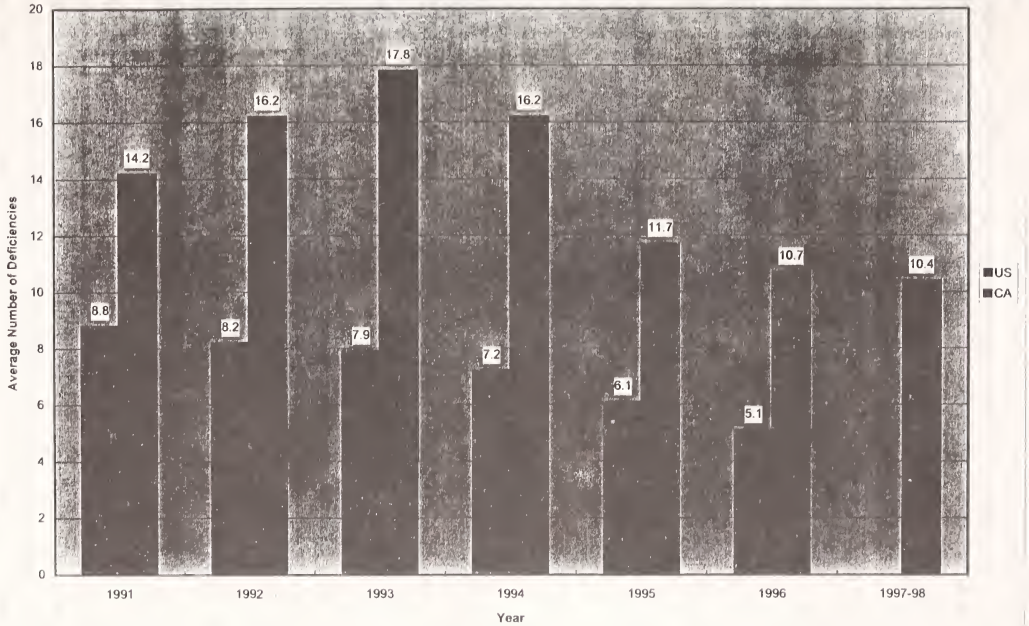
The Top Ten Deficiencies for all of the Certified Nursing Facilities in California for the Period January 1997 - May 1998



Source: On-line Survey Certification and Reporting Data, Health Care Financing Administration. Prepared by C. Harrington and H. Carrillo, University of Ca[illegible]rnia, San Francisco.

Figure 14

Average Number of Deficiencies Per Certified Nursing Facility in the U.S. and California



Source: On-Line Survey Certification and Reporting System, Health Care Financing Administration. Prepaared by C. Harrington and H. Carrillo, University of California, San Francisco.

The CHAIRMAN. I am going to let my two colleagues ask questions first. I will go to Senator Collins and then to Senator Moseley-Braun.

Senator COLLINS. Thank you very much, Mr. Chairman, for accommodating my schedule. When I listen to the testimony of our witnesses, it strikes me that there are two overarching problems that have been identified. One is the uneven quality and the ineffectiveness of the State surveys, and the second is the decline in enforcement and the rather puny penalties imposed even when problems are identified.

Dr. Kramer, I would like to start with you. I was stunned by your statement that there was a State survey going on concurrently with your survey and yet the results were very different. You found very troubling and severe problems. Apparently, the State survey did not. This raises the issue to me of the effectiveness and the quality of the State surveys.

Can you give us any insight as to why there is this disparity?

Dr. KRAMER. There is a substantial difference in the way that we conduct our review activities. Let me clarify what the differences are that enable us to find problems that aren't found by the survey process.

First, we collect information on a much larger sample. We do not start by focusing our review activities on a relatively few individuals with selected characteristics, as the surveyors do. Every quality of care issue is investigated in each nursing home because we look at all quality indicators for this entire sample.

The sample includes not only residents who are randomly chosen, but we also select residents who are at high-risk for quality problems, which I think is one of the keys. If you are going to look for pressure sores, you want to look at people who are bed-ridden or who have a prior history of pressure sores.

If you are looking for hospitalization and mortality problems, you want to look at new admissions to the nursing homes because they are more likely to suffer from those problems. So the first issue is the sampling one. The state surveyor don't cover the facility as systematically as we do.

The second issue is that we collect a more comprehensive set of information that isn't subjective. We collect a structured set of information on everybody that we include in that sample, using standardized approaches. Third, that information is entered into the computer and then we look at that facility relative to others and decide what quality problems to investigate. So we start globally and gradually narrow our focus an areas where the facility has problems. The State survey is not as systematic. They choose the sample and begin to target their activities as they go without the ability to compare the facility to other facilities.

Senator COLLINS. Dr. Harrington, you have suggested that even if the State inspectors do identify serious deficiencies that the enforcement by HCFA is so lax that really there isn't much of a penalty to be paid. That troubles me because while I believe there are many very ethical nursing home administrators who are running very good facilities where we could be proud of the care, that lack of enforcement sends a very troubling signal to unscrupulous providers.

Could you enlighten us? I notice on the chart you said that in, I think it was July 1995, HCFA made a decision to impose a moratorium on the imposition of civil monetary penalties. Well, one of the best ways to hit an unscrupulous provider is in the pocketbook. Why did HCFA do that?

Dr. HARRINGTON. Well, I can't explain why they did it, but the idea of the Act was that these penalties, and a range of other penalties would be given. Currently, even though the moratorium is off, they are only giving these penalties to the most severe situations. We envisioned that penalties would be enacted quickly and in a timely way for a whole range problems. So if it is was serious offense, a facility would get a higher penalty. If it is a minor offense, a facility would get a lower penalty. Now, in California, for example, it takes 3 years to collect some of these penalties. So the penalties are not swift and they are only given out for the most egregious situations.

Senator COLLINS. Mr. Chairman, thank you very much for allowing me to go out of order. I thank my colleague, also.

The CHAIRMAN. Senator Moseley-Braun.

Senator MOSELEY-BRAUN. Thank you very much, Mr. Chairman. This may respond a little bit to the query that Senator Collins made, as well as Dr. Harrington's response that she was surprised that we were back here talking about nursing home standards. One of the early battles when I got to the Senate back in 1995 revolved around trying to restore the OBRA 1987 standard of care that was in the law previously back in 1995.

There was an attempt to repeal the standards for nursing home inspections. Not to be overly partisan here, but I think it is an important point to be made, the only Republicans who voted for nursing home standards were Senators Snowe, Cohen, DeWine, Gregg and Specter. So we had a fight on our hands and the amendment to restore the nursing home standards did pass by a vote of 51 to 48, but it was a tough battle.

Senator COLLINS. I just want to point out I wasn't in the Senate at the time. [Laughter.]

Senator MOSELEY-BRAUN. I was just giving you a little background, Senator Collins, of I think part of the reason why, because we have had an uncertain trumpet, if you will, on this whole question of nursing home standards. And for the people in the field not to know whether Congress is serious about having standards for care or not, I think, has had an impact on the standard and quality of care. So I just wanted to give you that little bit.

But I have a question getting back to my earlier observation about the families because I am very concerned about families having the ability to—you know, if they come in and look at a loved one in a nursing home and the care is not adequate, I mean the family member will be the first one to know that, you know, grandma's room is not clean or that the food is nasty or that the diapers haven't been changed or whatever.

I know that, theoretically, at least, the families have some recourse with the State inspectors, but to what extent is it clear—you mentioned consumer information and advocacy. To what extent is it clear to families that there is a process in place for them that they can complain not just at the State level, but at the national

level, to HCFA directly, and that there will be some follow-through on their observations and complaints?

It seems to me we are sitting here with almost a presumption that it is going to be up to the bureaucrats to maintain a level and standard of care without regard for the fact that it really is the families that are out there on the front lines and most closely affected by this issue.

Dr. SCANLON. We would agree with you completely. In fact, I think that perhaps the most fortunate nursing home resident is one who does have family that is actively involved to be able to observe the care that is being delivered, as well as to sometimes provide needed assistance that the home is not providing.

There is, as you indicated, a mechanism or a procedure that a family member can file a complaint with the States or with HCFA, and complaint investigations, we think, are an important part of identifying problems in nursing homes. Unfortunately, we have not completed our work on looking at the complaint process, but preliminary examination suggests that some of the complaints are not always followed up promptly and the enforcement problem applies to complaints as well as to the annual surveys. When a deficiency or other problem is found in a complaint survey, there is not necessarily a strong action to effect a permanent correction.

Senator MOSELEY-BRAUN. Then I would ask, Mr. Chairman, if we could get a report back to this committee from HCFA regarding the process for families, what guidelines they have to the States as well as what is the process for direct intervention and reaction to family observations in the survey process. I would very much appreciate some information back on that.

The CHAIRMAN. Yes, we will take directive from you and from the committee as a whole to try to get that information. I don't know what is available, but we will get what is available.

Senator MOSELEY-BRAUN. And I have a second issue having to do with consumer information. Based on the statistics that we have been given in this regard, it does appear—they are very scary statistics and I don't know, Mr. Chairman, how much of this was talked about before. But given the percentage of the population over age 65 and the percentage of those people who are in nursing homes and the percentage of those people who are women, for those of us who are of a certain age, this is a very important hearing.

But in any event, my question is, apparently, of the nursing home population age 65-plus, much of that is paid for by Medicare or Medicaid. The question becomes what about private pay? Does anybody collect or have numbers, statistics, on where the private pay patients are going and how is that market operating? Do we have any information about that?

Dr. SCANLON. Well, the importance of Medicare and Medicaid is so significant that virtually all nursing homes are serving beneficiaries from those two programs, as well as private-pay patients. There is some variation across homes with some homes that are having more Medicaid and more Medicare residents than others, but virtually in all homes there is going to be a mixture of all three sources of payments.

Senator MOSELEY-BRAUN. I am sure that is right, but do you track—and the private pay probably is not de minimis, but it is very small, from what I can gather from the numbers we have. But do you track where those patients are?

Dr. SCANLON. It is tracked periodically in surveys of nursing homes. Private pay, out-of-pocket costs for nursing homes really are quite significant. There is a component of the nursing home resident population that is relying either on their resources or their family resources. This may be about 30 percent or 35 percent of the nursing homes residents, and they are generally paying several thousand dollars a month for care.

Senator MOSELEY-BRAUN. OK, but you don't—

Dr. HARRINGTON. I might point out that in the statistics that I presented, these include all the private-pay patients. So we have situations where patients are paying $5,000 a month and still having all these same problems, decubitus ulcers and malnutrition, and so on.

Senator MOSELEY-BRAUN. Again, I appreciate the information. I was just trying to determine whether or not there is a difference in the operation of, if you will, the private-pay market and the Medicare-Medicaid market for nursing home care and if there is sufficient information to track that. The numbers that we had did not disclose enough to be able to track the difference.

I thank you very much. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you for your kind attention and we will take your recommendations into consideration and hopefully be able to get you that information.

Dr. Scanlon, obviously, the report that you presented to us is a very, very troubling report. In fact, in my years in the Senate, I can't think of another report more troubling. There may be, but just at least on surface I can't think of one. Obviously, I look forward to focusing on the GAO's recommendations to a considerable extent.

But, first, I would like to ask you a few questions about the report's findings. First of all, can you tell us more about just the nuts and bolts, the procedure of how you went about the report? For instance, how long did your office work on it? How many people were involved? What were some of the specific tasks assigned to the clinicians who worked on the team?

Dr. SCANLON. I would be happy to. We began work on this immediately after you made the request to us last fall and began initially with work focused on the allegations of inappropriate care leading to death among residents in 1993. And for that work, we gathered medical records from a sample of nursing homes which involved really what I think of as a herculean effort on the part of at least five or six GAO staff working in California, probably in windowless rooms, not enjoying the area, xeroxing those records.

We are talking about records in some instances that will be several thousand pages long and probably, on average, about 400 or 500 pages long. And we did that for a sample of, as I indicated, 62 residents. Those records were then reviewed by two clinicians, two gerontologically trained nurses who worked with us as consultants on a part-time basis from about the middle of February through the end of June.

In terms of our own staff, we had four people working on this virtually full-time since last October to the present. Then at various times during the course of the study for different aspects, such as the copying of the records or the preparation of the report or some of the data processing work, we had to involve other people on a fairly intensive basis. So it was a significant effort to do all of this work.

The CHAIRMAN. I am glad to have you explain exactly all who were involved and the amount of time it took, and I think I should compliment you because when I asked you to do this last year, I said unless you can put adequate resources into it, don't do it. In other words, I was pleading with you to be able to do that and I think you have done that well.

Your project, of course, was undertaken at our request. We turned to you because of your expertise. We asked you to investigate the allegations that were brought to us which claimed that thousands of people had died as a result of malnutrition and dehydration and as a result of bad care and neglect in California nursing homes. This was an extraordinary effort and you took it to help the committee determine the validity of the allegations we received.

Were you able to confirm or disprove the allegations we brought to you for analysis?

Dr. SCANLON. We weren't able to either confirm or disprove them in totality. As I indicated, we had to limit the sample that we could review, and we did review residents that were in homes that had the highest number of deaths, again on the assumption that if we didn't find problems here, we might feel more comfortable about the homes that we couldn't review.

We did, I think, very convincingly demonstrate that there was inappropriate care for a significant share of the residents that we reviewed. Thirty-four of the sixty-two residents received inappropriate care, and again the nurses, in reviewing these records and getting assistance from Dr. Kramer and other clinicians, were conservative in terms of what they classified as inappropriate care.

We were not able to make a linkage between that care and whether or not it caused the resident's death. Very early in the study, we consulted with pathologists and were advised that to make a determination of cause of death, one really needs to rely on autopsy information. And for this group of 3,000 residents, there were fewer than 1 percent that had an autopsy and we felt that that was too small of a proportion and likely too skewed in an unknown way that we did not want to use that information in our work.

The CHAIRMAN. I guess at a point where we are talking about how bad things are, I should make note of the fact that Dr. Harrington in her testimony indicated that the Nursing Home Reform Act and the administration of it has resulted in some improvement, at least as far as we can tell from the evidence that she looked at and has been looked at. We have been emphasizing where the system has been falling down, and we, of course, should do that. And the problems we have found are serious and disturbing, as we have been saying.

But, Dr. Harrington, in your statement you seem to indicate that we have made some progress and I think I should acknowledge that progress that has been made in those areas where it has been made. And maybe just very shortly, not to be repetitive at length, but just to maybe repeat what you said.

Dr. HARRINGTON. Well, I do think there is some evidence of improvement. Restraint use has gone down somewhat, and probably the most important area of improvement is in the appropriate use of psychotropic drugs. So I think drugs are being used more appropriately. HCFA has put out a report that shows that there has been considerable progress in that area. But I have to say that, in general, I think the progress in the staffing area, which is the most fundamental area, has really not improved or it is pretty minimal.

The CHAIRMAN. OK, thank you.

Dr. Scanlon, industry critics of your report argue that you have made up your own categories for classifying the care problems found in California nursing homes and that by doing so you have greatly exaggerated the seriousness and the extent of these problems.

In fact, one of our later witnesses will say with respect to categories you used in the report—and I want to quote from that testimony, "But the fact is that HCFA has spent a decade developing a matrix measuring both scope and severity of violations. The HCFA standard of substandard quality care has been in use for years and is much less subjective. According to this more objective and accepted standard, only 6 percent of the facilities in California were cited as giving substandard quality of care," end of quote.

So I would like to have you explain again what you did to develop the categories you use in your analysis and which are depicted in the pie chart that we have on page 9 of your report. And could you respond to the criticism that they greatly exaggerate the severity and scope of problems?

Dr. SCANLON. We were very aware of HCFA's definition of substandard care, and in the pie chart we did two things that were different than that definition. For the group in red that is labeled "caused death or serious harm," we combined two groups that HCFA identifies. One is the substandard care group, which is the 6 percent that you made reference to, and, the second is the homes that had a deficiency that was considered immediate jeopardy.

The latter are the most serious violations in terms of severity that HCFA identifies. They are believed to present potential for harming residents. However, some of these violations are not counted in identifying homes as providing substandard care. We don't think that is appropriate. There are cases where a home lacks adequate infection control that presents immediate jeopardy to the residents of that home. In a population of this age and with these types of health conditions, not having adequate infection control is a very dangerous situation. That is one reason why we added them to this red category.

The second thing we did which was different is that we combined information from the complaint surveys that are done during the course of the year between the annual surveys because you heard yesterday and today about how predictable the annual surveys are and how they may give you a false impression about the quality

of care in the homes. We felt that the complaint surveys may provide us a much better measure about the care because they probably were a surprise.

We took the information from the complaint surveys and used it with the HCFA annual survey information to develop our categories. The State of California has a category for violations causing death and for serious harm. We added homes with violations to our red category. We feel very comfortable that this gives you a picture of where the serious quality of care problems are and how many homes are involved. I think we would be happy to discuss this further with anyone who feels that we have overstated the proportion that are providing serious problematic care.

The CHAIRMAN. I am going to go to Senator Breaux now and when Senator Breaux is done, then we are going to have to adjourn until 12:30. But would you please remember, Dr. Scanlon, where we left off here because I had some follow-up questions on that point?

Senator Breaux.

Senator BREAUX. Well, I want to thank the panel members for their presentation. Dr. Scanlon and Dr. Kramer, thank you for the work that you all have done in the GAO report.

I was looking through the report to Congress that HCFA provided and noticed a number of interesting things. I know you are familiar with it and probably have looked through it fairly carefully, but can you tell me if this report that we got from HCFA differs in any way substantially from the report that GAO did on the status of nursing homes?

Dr. SCANLON. Regarding the characterization of care problems, as I indicated, we attempted to be more comprehensive in terms of the measures of care that were available and used them to identify the share of homes that are problematic. There is a difference there.

There is actually agreement in terms of some recommendations. Certainly in terms of what the administration announced last week, that we do need to make surveys much less predictable, if not totally unpredictable. We do need to take firm and swift action when we find significantly problematic homes, such as those that have had serious deficiencies on a repeated basis. So we are in agreement on those areas as well.

I think that what is not discussed in either report is the issue of "will we carry out these actions." That is the critical point here.

Senator BREAUX. What is the validity of your report from GAO vis-a-vis the entire country when the report only focused in on one State?

Dr. SCANLON. There is no way to extrapolate from our report to the country. We did have and analyzed only information from California using the data collected by the State surveyors there. A comparable kind of analysis can be done in other States, but in doing that analysis I think we need to be very sensitive to the potential that the data are not comparable in the sense that surveyors may approach their jobs differently in different States. Therefore, the measured prevalence of deficiencies may mean different things in these States, and some attempt to adjust for that would be very critical to make a State-by-State comparison.

Senator BREAUX. The HCFA report points out, in sum, the pattern of citations suggests that States probably vary widely in their ability or willingness to detect serious problems in nursing homes, even given likely variations in the quality of nursing homes from State to State.

Can anyone on the panel comment on that? Does that suggest that the States are not able to do the inspection and regulation of nursing homes and that it should become a Federal responsibility because of the inconsistency? Is there an inconsistency from State to State on the interpretation and implementation of Federal guidelines? Can anyone comment on that?

Dr. KRAMER. In some of the work that we completed in the early 1990's, we involved ten States, in a study where we did replicated surveys, much like we did in the two facilities in California. Although we could not do a State-by-State comparison, we found inconsistencies in identifying quality of care problems across these 40 surveys in 10 other States. So I think this whole issue of inconsistency is an issue in multiple States.

Senator BREAUX. In your opinion, does that call for taking that responsibility away from the States and having a national standard?

Dr. KRAMER. Whether the States can accurately survey or not is the question, I guess, you are getting to, and I think with proper revisions to the survey process and a much more structured process, it may be possible for them to do it. It will take significant changes in how they conduct the survey and I am not sure they can all respond.

Senator BREAUX. Is there confusion among—I mean, is it a "no, that is your job, no, this is our job, you should have done that, no, you should have done it" battle between the Federal Government and the States with regard to enforcement? Do you see that as a problem?

Dr. SCANLON. I have seen that as a minor issue, or a relatively minor issue in the work we have done to date. We have another study that is underway at the request of the committee to look at enforcement not only in California, but we are looking in Michigan, Pennsylvania, and Texas. We know that there are differences in recommendations made to HCFA to impose sanctions and that not all of them are followed up by HCFA. There is then a question of what leads to State recommendations not always being heeded and that is part of the second study that we will be reporting on for you later.

I think there may be some confusion about how to apply certain elements of the system and those are the kinds of things that we should be looking to clarify so that that is not the problem. There is a reason that we turned to States initially to ask them to be involved in certification because historically they were the licensers, and still are the licensers of nursing homes. Even though these are separate, there is some connection between the two functions; To federalize certification and take it away from States would create a system that had to develop means to coordinate with licensing and may not be nearly as efficient.

Senator BREAUX. I was reading your summary and the background of your report, Dr. Scanlon, and you talked about the Budg-

et Act of 1987 introduced major reforms in the Federal regulation of nursing homes and responded to the growing concerns about the quality of care that the residents received. Among other things, these reforms revised care requirements that facilities must meet to participate in the Medicare or Medicaid program. It modified the survey process for certifying a home's compliance with Federal standards. It introduced additional sanctions and decertification procedures for homes that failed to meet Federal standards.

Can anybody on the panel comment on the effectiveness of what we did in 1987? This was major reform. I think most people that participated in that thought that we had basically solved the problem. That is not what we heard yesterday.

Dr. Harrington.

Dr. HARRINGTON. I think the reforms were very good, but we have a long way to go to get them implemented. And the weakest part of what we have done so far is still the enforcement process. So if we can improve the enforcement process to make it more effective, that is what we want to do.

I want to go back to the question you raised a minute ago about California and how does it compare. We do have statistics on California deficiencies and all the other States in the Nation since 1991, and California is No. 2 in the Nation in terms of the average number of deficiencies it issues per facility.

Senator BREAUX. No. 2 in which way, the bad way or the good way?

Dr. HARRINGTON. In a good way, being strong on enforcement. So we are seeing it is one of the strongest States on the national statistics and yet we are seeing these quality problems.

Senator BREAUX. If it is one of the strongest States in compliance and you still see that 30 percent of them cause death or serious harm.

Dr. SCANLON. I think it is the opposite way, good on enforcement, bad on compliance.

Dr. HARRINGTON. Good on enforcement, right, good on enforcement. Yet, we are still having these problems.

Senator BREAUX. You would presume that if you are good on enforcement, you would get compliance.

Dr. HARRINGTON. That is the problem. It is not translating into improving the care.

Senator BREAUX. If we are very good on enforcement and people still aren't complying, there is a real breakdown somewhere.

Dr. SCANLON. Senator, I think maybe enforcement was not the correct word. It is good on identification, not necessarily good on enforcement.

Senator BREAUX. That is a big difference.

Dr. HARRINGTON. Yes.

Senator BREAUX. If you are saying, boy, there are a lot of problems out here and you don't do anything about it, then you still can have a lot of problems.

Dr. HARRINGTON. Well, they are identifying the deficiencies in some cases, but they are not following through in getting facilities to correct.

Senator BREAUX. Well, that clarification makes a great deal of sense.

We have to run. I thank you all very much for being with us.

The CHAIRMAN. I am going to recess the hearing until 12:30. Thank you all very much. [Recess.]

The CHAIRMAN. I think everybody for their being on time, and we will proceed now with our questioning and then immediately to the second panel for the day.

As you remember, Dr. Scanlon, I was telling you that I wanted to continue where you left off with my questioning. We were talking about the categories that GAO had set up and some of the criticism made by the industry about your categories. I would like to ask a question about the first, most serious category.

The GAO report states that the residents in about 30 percent of California nursing homes are exposed to conditions that your report classified as, quote, "caused death or serious harm." This finding has been criticized by the industry as wildly exaggerated. Respond to the critique, please, and is there any reason to believe that this figure is on the conservative side, and if so, why?

Dr. SCANLON. Well, Senator, as we were talking before, we believe that even though we did not use the single definition of substandard care which HCFA has, each of the components that make up the homes in that red piece of the pie, the 30 percent of homes, is a home that is providing and has been documented as providing poor care, and that it is very important for potential residents as well as the residents that are in these homes to know that fact.

In terms of whether this is an understatement, both our work as well as the testimony you have been hearing over the last 2 days indicates the very serious problem we have with potential problems with records not reporting that care is not being delivered, the problem with predictable surveys that allow homes to be ready and to look better on survey day than they look during the rest of the year. And, in addition, as Dr. Kramer has indicated, a more effective method for doing the survey will very often identify more problems.

So the 30 percent, again, is perhaps the conservative estimate. In everything that we have done, there has been no attempt to exaggerate the nature of this problem. We have tried to be conservative and as factual as we possibly can.

The CHAIRMAN. How many people does the 30 percent represent?

Dr. SCANLON. In California, that would be about 40,000 residents.

The CHAIRMAN. The report also notes that 33 percent of the nursing homes were found to have violations categorized as causing less serious harm. What does "causing less serious harm" mean, and can you give me one or two examples of these kinds of violations?

Dr. SCANLON. The less serious harm at times involves some of the same poor care that is in the more serious "caused death or serious harm" category. But the differences are that it is not something which involves an immediate threat or a continuing threat to residents or something that was more widespread in the facility.

We do have some concerns about the scope definitions that are used in the survey process in that nursing homes serve a variety of patients and a home can be ill-equipped or ill-prepared to deal with a particular kind of resident. Even if all the residents having a particular need are not getting good care, if they are a relatively

small or moderate fraction of the home's residents, then under HCFA's definition the scope is not going to be considered widespread. It is going to be considered less prevalent, and we think this misrepresents what the quality of care will be for individuals with those kinds of needs if they were ever to enter this home.

If you would let me turn to our report because, frankly, in the different categories the examples in some respects start to sound the same. I want to make sure I give you examples from the "caused less serious harm" category. It is on page 12 of our report.

One example is that we had a resident that was evaluated on admission as being at low risk for developing a pressure sore, and a month later that resident was admitted to the hospital with pressure sores on buttock, thigh, calf, and foot. The hospital's physician could not perform surgery on the most serious of these sores because of the resident's deteriorated skin condition. The deterioration was caused by severe dehydration and infected pressure sores. This resident died 2 days later from infected pressure sores, sepsis, dehydration, and septic shock.

Another example is an individual who had chronic obstructive pulmonary disease, arthritis, dementia, and several serious pressure sores. She had a plan of care that called for a special mattress to deal with her pressure sores to promote their healing, for assistance with eating and participation in a feeding program, and for turning and repositioning every 2 hours.

Surveyors, in observing the care of this woman for 10 hours over 2 days, showed that the woman was left in a wheelchair without the pressure-relieving device and without being repositioned, and that she was left in her room alone to eat without assistance, encouragement, or participation in a feeding program.

These are examples of less serious harm.

The CHAIRMAN. So a natural follow-up, because this seems like a very serious matter and serious violation to me. So then I have to ask if you think that the categorization that is used here is appropriate for this kind of serious problem that you just described.

Dr. SCANLON. Certainly, these particular instances, we think, are very serious. The issue in terms of distinguishing between the two categories is both the prevalence of these kinds of problems and the immediate threat that a problem may represent, or a continuing threat that a problem may represent for residents.

We cannot be at all content with problems this serious and say that our only concern should be focused on the homes in the red category because this kind of care is clearly as unacceptable as the care in the red category and we need to take steps to make sure it does not occur.

The CHAIRMAN. What are the implications, in your view, of the ways that these particular violations are categorized? Would a nursing facility be sanctioned for such violations under the current system?

Dr. SCANLON. Under the current system, while there is potential for sanction, the reality is that the sanctions will very, very unlikely be imposed. We found that, again, 98 percent of the time that a deficiency was found that there was a grace period granted to correct the deficiency. For these kinds of violations, the grace period would be granted and as long as a correction occurred within

the grace period, we would find that a Federal sanction would not be imposed.

In our red category, we have found that the grace period is granted in most cases as well. Some of those homes do not eventually come into compliance and that ultimately 17 percent of those 400 homes received a Federal sanction. So even though care problems for homes in the red category are even more serious, sanctions are not prevalent in that category.

The CHAIRMAN. Again, for clarification, 33 percent represents how many thousands of people?

Dr. SCANLON. It would be approximately 45,000 residents in California.

The CHAIRMAN. In the report, you note that in medical records that were reviewed by your experienced medical professionals certain discrepancies or omissions were found. In what percentage of the medical records reviewed were implausibilities or suspicious omissions of information found?

Dr. SCANLON. That involved the record review of the 62 cases that was done by our consultant nurses, and in 29 percent of those records we found either inconsistencies or omissions that led us to question the validity of the records.

The CHAIRMAN. So it would be about 29 percent?

Dr. SCANLON. About 29 percent, right.

The CHAIRMAN. How about just a few examples from the report?

Dr. SCANLON. Well, one example was a person that was admitted to the hospital and diagnosed in the hospital as having a fracture in a bone in their leg and that the fracture was likely to have occurred about 3 weeks before. In looking at that person's medical record in the nursing home, what was found was that all of the nursing care documentation for that 3-week period was missing, indicating that there was no information about whether this broken leg had been identified, whether there was any treatment applied during that time period. There was a real concern that a person had this problem and the home knew that something may be happening and yet they did nothing about it.

Another example is a person who lost a significant amount of weight in a relatively short period of time, almost 10 percent of their body weight, while the medical record indicated that they were eating 100 percent of 3 very high-calorie meals each day, as well as receiving several high-protein supplements during the course of the day. It was the view of the nurses that reviewed this record that it would be impossible to be consuming that much food and lose this much weight when there was no medical condition that could explain such weight loss.

The CHAIRMAN. Your answer leads me to believe that the veracity of medical records are, at the very least, to be questioned, and I think that we also had an indication from people yesterday that that could be the case. We also learned from this testimony yesterday that the falsification of medical records could be a real problem in California nursing homes.

The Health Care Financing Administration uses what it calls MDS to assess patients and develop care plans. Is the integrity of the MDS affected by questionable and/or falsified patient records, and if so, how, and is the integrity of OSCAR also in question?

Dr. SCANLON. Well, I think we need to view the MDS as simply another portion of the medical record. It is very much dependent upon information that is gathered and recorded into the record, and then part of it is being transcribed to the MDS itself. And we do need to have significant concern about the integrity of the information that is in the MDS. It can be a very powerful tool for quality assurance to identify facilities and residents for targeted reviews so that we can be more assured about the quality of care being provided.

We are also now embarking as of July 1 of this year on the prospective payment system for Medicare skilled nursing facilities, which is also going to be reliant upon the MDS for categorizing residents and deciding how much the facility is going to be paid for the care of an individual resident.

We think that making sure that the MDS data are valid is a critical task that HCFA faces. We know that they have plans underway to try to address this task. Our concern is that those plans are not going to be in until the year 2000 and that we really need to think about the consequences of operating with poor data from the MDS between now and then.

In terms of OSCAR, I think that the issue is, again, while the surveys do not rely exclusively on the records for residents' care in the homes, they in part rely on that information. Therefore, OSCAR information which summarizes the survey is compromised by poor MDS and medical record data as well.

The CHAIRMAN. I would like to have you refer to the recommendations that you have. What else should we know about these recommendations? For instance, I am interested in, among other things you might want to mention, but particularly cost, difficulty of implementation, things of that nature.

Dr. SCANLON. In terms of the recommendations, we worked to stay within the scope of what our study involved. And, in fact, in presenting the recommendations to both HCFA, the Department of Health Services, as well as to industry representatives, they all said that we didn't go far enough, that they had other ideas which might improve the quality of care.

We did, as I said, though, stick to the areas that we felt flowed from the information that we had gathered and analyzed. The idea of dealing with predictability of surveys is something that we think is very feasible with no additional costs. The administration has already indicated that planning evening and weekend surveys is something that they are going to require the States to do. We think that is a very positive step.

Our idea of dividing the survey has received more resistance. We think that this is something where you may balance an option that involves no additional resources and creates once a year more of a presence in homes over the course of the year with a potentially more effective survey. We think it is particularly problematic that a home may be visited only every 12 to 15 months. That is too long of a period for us not to know about the care that is provided in those homes.

In terms of stronger enforcement, again, we think the administration's initiatives take steps in exactly the direction that we identified to require that homes having serious violations not be given

a grace period, to require that homes that have serious violations be forced to demonstrate through survey visits that they have come back into compliance. These things are possible, again, without additional resources.

Our recommendation along the lines of what Dr. Kramer's work indicates that a survey involving a larger sample of residents could be much more effective in identifying problems is something that potentially would cost additional resources. However, it is not clear whether those resources can come from another part of the system and we weren't in a position to be able to identify whether there needs to be a net addition or whether there needs to be a reallocation.

The CHAIRMAN. But what you described doesn't cost much, or if it does, it could lead to reallocation of resources, but would, regardless, have immediate benefits, you feel?

Dr. SCANLON. We think it would have an immediate impact. One of the things that we began to appreciate during our study is that many of the elements for quality assurance, if not all that we may need for the moment, are in place. What really needs to be done is that they be effectively applied, and that involves using the provisions of OBRA, using the provisions of the regulations and applying them with vigor to ensure that we have quality care.

The CHAIRMAN. Thank you, Dr. Scanlon.

Dr. Kramer, I need to start out my questions with you just to have a short description of your role in this report.

Dr. KRAMER. The GAO staff approached us to conduct these concurrent surveys with the State survey team and we used an approach that I developed with a team of individuals at the University of Colorado Center on Aging. Two of our staff members then conducted those concurrent surveys with the State survey team in California and we reviewed those results, presented them to GAO staff, and also at the same time presented them to HCFA staff; sharing our findings on the quality of care in those nursing homes.

I was then involved in reviewing the portions of the GAO report that corresponded to those concurrent surveys. Several of those are areas that Dr. Scanlon has discussed. Finally, I was also involved to some extent in some of the record review activities particularly relating to physician care issues in nursing homes.

The CHAIRMAN. I understand that your review looked into the quality of care in these two homes to a considerable extent, but your surveyors, accompanied by GAO staff, found that serious quality of care problems existed in the homes surveyed. They found that the State survey teams did not identify some of the quality of care problems found by your team.

Can you give us an example of problems related to patient care that the State survey team missed which your team identified?

Dr. KRAMER. Many of the problems that our team identified had to do with patterns of care that produced either potential or actual harm. And one area we identified as a problem in both nursing homes were the nutritional problems, and let me give you an example of a case—

The CHAIRMAN. Let me interrupt you. I am going to ask you to start over. I am going to have to call a recess because I have just been notified there is just 6 minutes left on this vote and that is

about how long it takes this guy to get over there. So we will recess just for a minute. If any other Senator comes back, I would urge staff to have them reconvene the committee to ask questions of this panel so that we don't lose a lot of time.

[Recess.]

The CHAIRMAN. Dr. Kramer, you start again with your answer to my last question and I won't repeat the question.

Dr. KRAMER. I showed you how we used our screen to identify problems in the nutritional areas. We found nutritional problems in both nursing homes that were not detected by the surveyors, and let me give you some individual case examples of some of these problems that we detected.

One of them was a longstanding resident with schizophrenia and depression who was dependent in many activities, including eating. His weight when we saw him was 83 pounds and it had dropped 12 pounds in a year. And the staff was feeding the resident and he was consuming 30 to 40 percent of his meals.

Now, the care plan said that they were to offer a meal substitute if intake ever dropped below 75 percent. However, there was no evidence of any interventions, no nutritional assessments on a regular basis. One nurse noted that nourishment was given between meals, but it wasn't clear what it was, and there was no order for a nutritional supplement. So we had low weight continuing to decline, and even though there was some identification of the problem, there was no follow-through.

I have several other examples of the same kinds of problems. In some cases where there were pressure sores or skin infections, conditions that although not directly caused by nutritional problems, nutritional problems can easily be one of the major contributing factors.

The CHAIRMAN. Could the approach that you used to find quality of care problems in California nursing homes be adopted for State survey agencies? Would there be any difficulty if we were to do that?

Dr. KRAMER. Yes, I believe the approach that we have used and the principles in the approach that we have developed could be used in the State survey process. The obstacles—first of all, there would have to be some refinement so that it could be integrated into the other survey activities that go on at the same time, recognizing that we focused largely on quality of care and somewhat on quality of life. But it could be expanded to address those other issues.

Another issue is it would certainly take increased training or new training of surveyors because as I spoke about earlier, it is a major change in the way the survey is conducted. So surveyors would have to learn this new approach.

The issue of resources is the one that keeps coming up in the context of this, and although we don't have a perfect test of the resources required by our approach compared to the survey, let me give you an example of one of the facilities in California.

We had two people in the facility for 2½ days, a total of 5 days, to look at the quality of care information. The State survey team had six people in for 5 days. Now, this is the facility where they were able to find some of the problems that we were able to find,

and I also have to acknowledge that they had to look at other issues. On the other hand, we are talking 30 days of person-time as opposed to 5 days of person-time, and then not being able to detect all of the quality of care problems that we were able to find. Somehow, I think if you restructure the activities, you don't necessarily have to increase total resources.

The CHAIRMAN. Has this approach ever been presented to HCFA, and if so, has HCFA modified any of its survey processes as a result?

Dr. KRAMER. Yes, we certainly have presented this to HCFA. HCFA has funded its development and shown an interest in the approach that we have developed over a number of years. No, they have not changed the survey process along the lines of what we have recommended.

The CHAIRMAN. Senator Reed, if you would like to have any questions or anything, I would be glad to defer to you.

Senator REED. Mr. Chairman, I think you have several questions you want to get on the record, and the time has been so interrupted, I would defer to your questioning.

The CHAIRMAN. OK. Well, thank you very much, then.

Dr. Kramer, one more question and then maybe I will ask Dr. Harrington some. In your testimony, you recommended five changes to the nursing home survey. Among them was a review of the quality of care for residents that are new admissions to nursing homes. Don't nursing homes already do this when they fill out their resident assessment form, and how is your recommendation important to the existing practice of assessing residents?

Dr. KRAMER. Nursing homes complete the resident assessment form on new admissions to nursing homes, but that isn't an evaluation of quality of care. That is an assessment of status that they complete for every resident.

The issue that I am addressing is that new admissions to nursing homes are an extremely vulnerable group. As hospital stays have gotten shorter, the nursing homes are confronted with sicker patients and some of the problems like the ones Dr. Scanlon mentioned that occurred within the first month of admission with somebody rapidly getting decubitus ulcers and having to go back to the hospital and dying are typical of the kinds of problems that can occur among new admissions.

Other kinds of issues that arise with new admissions to nursing homes—people come in, they are somewhat confused. They rapidly get more confused and agitated, sometimes, which can be delirium. That can lead to restraints, psychotropic medication use, problems with feeding. Again, you can get into a downward spiral of problems because it is the new admission period.

Let me mention a third kind of issue that is equally critical. A stroke victim can come into the nursing home and because the facility does not have an adequate rehabilitation program, such an individual may not get discharged to the community within about 3 months. Well, the research has shown repeatedly that if you don't go home from a nursing home in 3 months, you are unlikely to ever go home. So, without adequate rehabilitation, you can have very poor outcomes in these nursing homes.

Those are the kinds of issues that you want to be looking for in a group of new admissions to the facility. But if you go in on a given day and you just look at people who are there, you are not going to find out about people who have been admitted previously and for whom bad things have happened. You won't be looking at that admission period. So, new admissions are a very vulnerable group and part of the survey should be devoted to looking just at those people.

The CHAIRMAN. Dr. Harrington, are some facilities currently meeting the standards for staffing that you set out within the current Medicaid and Medicare reimbursement levels? And before you answer, I would like to give you a "for instance" that we heard about last fall during a forum I had on malnutrition in nursing homes.

We were trying to point out what is called best practices in facilities that were doing innovative things in this area, particularly in regard to staffing. In fact, one of these facilities, Providence Mount St. Vincent in Seattle, is doing their program with mostly Medicaid funding, and I believe its Medicaid funding is in the area of 80 percent funding.

Dr. HARRINGTON. Yes, I am familiar with that home and there are some excellent nursing homes that not only meet the typical staffing level, but they go well beyond the staffing. These tend to be homes—some of them are hospital-based. We know there is a wide variation in the staffing levels, so some homes have excellent staffing and they can do it on the Medicaid rate. The issue is how do they spend their money.

The CHAIRMAN. And this would also be within the concept of your testimony which you were suggesting within the spirit of your testimony?

Dr. HARRINGTON. Yes, because we know that some homes have dangerously low staffing and that is not being picked up. Yet, they are being paid by Medicare and Medicaid to provide staff and they are not doing that. So it borders on a fraudulent situation when the care is not delivered.

The CHAIRMAN. I want to use your expertise for something that perplexes me and that is the survey and certification protocol as currently implemented by HCFA for nursing homes, whether or not that is effective.

Dr. HARRINGTON. Well, I think there are a lot of problems with it and the protocols need to be changed. I think Dr. Kramer has talked about a number of things that could be changed in the survey process and one of the——

The CHAIRMAN. Could you address specifically the scope and severity chart?

Dr. HARRINGTON. Well, yes. I think——

The CHAIRMAN. Is that an effective tool?

Dr. HARRINGTON. The scope and severity—at the present time, I feel that it is unnecessarily complex and it is confusing. And I think it is very difficult for the surveyors to distinguish between the areas, as Dr. Kramer and Dr. Scanlon mentioned, between what is pattern and what is widespread. I think the whole scope and severity issue needs to be rethought and the surveyors need guidelines on how to really decide what the scope and severity is.

The CHAIRMAN. One of our later witnesses today states in his original written statement submitted to the committee, quote, "But the fact is that HCFA has spent a decade developing a matrix measuring both scope and severity of violation. The HCFA category of substandard quality of care has been in use for years and is much less subjective," end of quote. According to this objective and accepted standard, only 6 percent of the facilities in California were cited as giving substandard quality of care.

Would you comment?

Dr. HARRINGTON. Well, I think there has been a lot of testimony here that the California surveyors are not picking up what is real substandard care. So they are only citing this in 6 percent of the facilities, but they should be citing it much more often.

After all, I think that is a little bit of a misstatement, what was said, because these scope and severity standards have been used only since 1995. So it is really a test period and I think we have to really raise serious questions about whether or not they have been effective in that time period. And if it doesn't work, we need to go back and look at what does work.

The CHAIRMAN. Can States use existing data systems to identify and weed out the problem facilities, and can the current data systems reveal facilities that have inadequate staffing?

Dr. HARRINGTON. Yes. We don't need a complicated data system, and when the surveyors go out to the site, they are given data by the facility and that can be looked at right at the time of the survey, plus we have 4 years of existing data on these facilities that can be used and reviewed by surveyors before they ever walk in the door. I think the concern is it is not happening, that the data are not being used to identify those problem facilities. Something is wrong. When a facility turns in a report and they show zero staff on that report and no one picks it up, then there is a problem.

The CHAIRMAN. I assume you are familiar with the Institute of Medicine study on staffing that was published last year?

Dr. HARRINGTON. Yes. I was on that committee.

The CHAIRMAN. Well, then, you are very familiar with it.

Dr. HARRINGTON. Yes.

The CHAIRMAN. What do these studies have to say about current staffing in nursing homes, and are there certain recommendations that you would bring to our attention today?

Dr. HARRINGTON. Yes. That study was a study of national experts that reviewed all of the research literature and the studies and the evidence on staffing. And they concluded that the staffing is too low in nursing homes to provide adequate care. They recommended, at a minimum, there be 24-hour-a-day RN staffing and that the staffing needs to be increased, and HCFA needs to focus efforts on staffing in this area.

The CHAIRMAN. In your report, "The Regulation and Enforcement of Federal Nursing Home Standards 1991–96," you discuss policy actions that HCFA took when implementing its new enforcement standards in July 1995. Some critics allege that, generally speaking, the policy actions that HCFA created in doing so create a system that is both permissive and forgiving toward nursing homes. That is my first question, whether or not you agree with this, and if so, can you give us an example of one or two policies that allow

for a too permissive system, perhaps even the policy on revisits or civil monetary penalties?

Dr. HARRINGTON. Yes. I think all of these informal policies that were adopted by HCFA that constrain the enforcement system need to be revised and relooked at because they do not allow for swift and effective enforcement. I think letting facilities off the hook on the civil monetary penalties is a bad idea. One of the most effective ways to enforce the current standards is to withhold Medicare and Medicaid payments for new admissions to a facility.

The CHAIRMAN. And we know that is not done very often.

Dr. HARRINGTON. It is very seldom done, and that is an extremely effective tool.

The CHAIRMAN. You were dealing with nursing home quality issues in 1987 and you continue to be involved today in a constructive fashion. We compliment you on that. We also acknowledge again that this is deja vu for you because you went through these as a State administrator in 1975, I think you said; also, a great deal of research you have conducted for HCFA relating to quality of care in these homes.

Have you been able to provide HCFA with recommendations for improvements, and if so, has HCFA taken steps to implement your recommendations?

Dr. HARRINGTON. Well, I have worked closely with HCFA over the years and I think some HCFA staff are very interested in some of these issues, and I would like to use the issue of staffing as an example. This issue has been on the drawing board since before 1990 because in 1990, Congress passed a resolution to request HCFA—I believe it was in OBRA 1990, to ask HCFA to conduct a study of staffing in nursing homes, and that study hasn't yet been completed.

Since then, we have asked HCFA to give some attention to what can be done to enforce the minimum staffing standards and increase the standards. If you notice the President's initiatives, which I applaud—I think they are excellent—there is not one word in those new initiatives about staffing.

The CHAIRMAN. Do you get discouraged being on contract and giving recommendations and not having recommendations followed very often?

Dr. HARRINGTON. Yes, sometimes.

The CHAIRMAN. Dr. Scanlon, the original statement from one of our subsequent witnesses criticized the GAO report on the grounds that the sample of medical records and the sample of nursing homes that your team analyzed was much too small to represent all of California's facilities. They argue also that you targeted bad facilities, so obviously you were going to find bad care.

The conclusion they draw is that you have irresponsibly misrepresented the state of care in California nursing homes. I think you should respond to that while you are here.

Dr. SCANLON. Mr. Chairman, if you or anyone else were to look at our report carefully, you would see that we make a very clear distinction between the two parts of this report. The one study dealing with the allegations of poor care in 1993 involving that sample of resident records—we make very, very clear that that component of the study is not representative of all of California's

nursing homes. It is not even representative of the homes that were involved with alleged deaths which numbered 900 homes. We make clear that the results apply to the sample of homes that we selected.

As I indicated earlier, the reason that we selected homes that had a higher prevalence of death was to be able to reach a stronger conclusion. Death certificates contain a limited amount of information. They have the diagnoses that are listed as causes of death. However, there are potentially other conditions that may be involved that contribute to death and they say nothing about the care that individuals received.

Therefore, in looking at this as a problem that we needed to research, we thought it was possible that nursing homes could provide good care and yet those diagnoses would still be on the death certificates. And we did find in 45 percent of the cases reviewed that the homes provided acceptable care. That was why we sampled homes with more deaths because we assumed that if it was demonstrated that those homes were providing reasonable care most of the time, people would be more reassured about the homes that we were not able to sample.

The CHAIRMAN. Senator Reed, if you have any statement or anything you want to say?

Senator REED. Mr. Chairman, just two questions. The panel has made recommendations very strongly to withhold Medicare payments. I was just wondering, on a practical basis, what consequences ensue. You are much more expert on the system than I, but essentially you would be paying for care that has already been given or not given, but the impact would be immediately on the facility and the patients living in the facility. It sounds very compelling, but does that make sense in practice?

Dr. HARRINGTON. Well, I think I mentioned that that is an effective tool, but I think it should primarily be used to withhold from new admissions, so that a facility would be told that you cannot have any new admissions and we are not going to pay for any new ones until the problem is corrected, and not withhold it for patients that are already in the facility.

Dr. SCANLON. Senator, even when a facility that is terminated from the program, there are provisions to continue payment for a period of time for residents that are currently in the facility, recognizing that the facility needs to be able to provide care to those residents.

It is an extreme measure in that instance, and so therefore one has to consider how to deal with making sure that the care of residents remains adequate either by transferring them to another home or by having this home come into compliance, which would really be preferred; and that could involve sometimes a change in management or sometimes it would be that the home has decided that the program is serious and it really does want to be a deficiency-free home.

Senator REED. It seems to me—and, again, you have much more experience in this—that these troubled institutions are usually operating week to week in terms of their cash-flow and may have numerous other problems. When this type of sanction is imposed, in

many respects I think they make a case, compelling or otherwise, that, well, if you do that, then we are out of business.

Is that your sense from what you have studied?

Dr. SCANLON. We were not able in this study, and I do not know of a study that has gone into that level of detail in terms of the financial situation that different homes are in. There is an extremely wide variation in the costs of care across homes, as well as in the financial health of homes. It has not been demonstrated that there is that strong of a correlation between quality of care and some of these financial indicators. Again, when a home is terminated, the cash-flow is not going to immediately change. There is a protection there for residents.

Senator REED. Dr. Scanlon, you suggested very strongly in your recommendations to eliminate the grace periods in terms of the ability to cure these. Might you want to elaborate a bit about what the consequences would be in that situation?

Dr. SCANLON. The grace periods are allowing homes with serious violations and serious repeated violations to be able to correct those violations within the grace period without any sanction. There are sanctions, including the civil monetary penalties, that could be imposed on such homes.

We really believe that there is a need to get the attention of facilities. A pattern in which you are allowed to fall into deficiencies or violations, correct them, and then fall back, with no consequences, seems totally inappropriate for Medicare-Medicaid beneficiaries.

Senator REED. Thank you very much. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Reed. You are very attentive to the work of this committee and I ought to recognize that from time to time. You don't miss very many meetings, and thank you for coming this time.

Senator REED. Thank you.

The CHAIRMAN. I am done asking questions of this panel, so I thank you very much for coming and for your expertise. Hopefully, you can stay and listen to the last panel that we have.

Before I call the next panel, I would like to respond to a comment that was made about a vote that we had in 1995 or 1996 on the issue of who should have prime oversight for hearings, and that was about 2 hours ago before we made our break.

So far, this committee, not only today but most everything we do, has done a pretty good job of keeping politics out of the hearings. As I mentioned in my opening statement yesterday, this is much too important an issue to turn it into a political football. I set the tone last week for bipartisanship by immediately embracing the President's initiatives and pledging to work with him.

Now, some comments were made, as I indicated, that seem to be some political finger-pointing. I would just remind my colleagues that these problems that we have uncovered represent a very clear and present danger to citizens in California. We need to devote our entire attention to fixing these problems, and fixing these problems right now. Political finger-pointing doesn't help; in fact, it hurts. What we need to foster is a spirit of resolve and cooperation. I think finger-pointing threatens that spirit.

Those who are critical of a vote back in 1995 are defenders of Federal oversight. Well, the one thing that we do know about Federal oversight is—we are seeing it exhibited here today—the Federal Government, which right now has responsibility in this area, has done a very lousy job. The HCFA report issued last week is proof of that. It is a self-indictment of Federal oversight. So I hope that we will keep our political finger-pointing out of the process and keep on the high road because we want to get this issue dealt with.

Our third and final panel is composed of——

Senator REED. Mr. Chairman.

The CHAIRMAN. Yes.

Senator REED. I have to leave, but could I just make a brief observation.

The CHAIRMAN. Yes.

Senator REED. First, let me commend you for holding these hearings, and doing it in a way in which you are attempting to address a very real problem across this country. It is a very serious problem, as you point out. I also commend you for interjecting the spirit of a professional, objective review of what is going on. That is important.

It is important, too, to note that this is a problem that is recognized by the administration, by the President——

The CHAIRMAN. Yes.

Senator REED [continuing]. And recognized by HCFA. I think you will hear how they are attempting to address these problems. We have had a structure in place now over several years where essentially we have delegated responsibility to the States through HCFA to enforce these regulations. What we are hearing today represents a failure, if that is the term you want to use, on behalf of not just HCFA, but State agencies and people very much closer to the problem.

I would suggest that we have arrived, over several years of debate, at the conclusion that we need a good, positive, strong Federal role in this process. To totally defer regulation and oversight to the States would create a situation that might even be much worse in California than this report points out. In the spirit of trying to determine the proper Federal role to accomplish high quality care, I think these hearings can be very productive and useful.

Thank you.

The CHAIRMAN. Also, Senator Reed, we are going to have to commit ourselves to making sure that we follow up in many ways, including oversight of the President's recommendations, and I think if they are carried out, they will go a long way to help.

Senator REED. I think you are right, Mr. Chairman. I think also we have to ensure that HCFA has the resources to do this job. Sometimes, we are all guilty of criticizing Federal agencies, and lo and behold they have been hamstrung by not having the resources to get the job done. So if we want them to do the job, we are going to have to give them the resources and the direction I hope this particular panel gives them the direction and we will have to work on other panels to give them the resources.

The CHAIRMAN. Thank you, Senator Reed.

Senator REED. Thank you, Mr. Chairman.

The CHAIRMAN. Our third and final panel is composed of interested parties. We have with us Mr. Michael Hash from HCFA. Ms. Kimberly Bell from the Department of Health Services for the State of California was invited and declined our invitation.

We also have with us Mr. Sheldon L. Goldberg, of the American Association of Homes and Services for the Aging; Dr. Dennis Stone of the California Association of Health Facilities; and Dr. Paul R. Willging, with the American Health Care Association.

Mr. Michael Hash is the Deputy Administrator for HCFA, and that agency serves 60 million elderly, disabled, and low-income Americans through its Medicare and Medicaid programs. HCFA serves as the quality assurance focal point for these two programs.

Mr. Goldberg is the president of the American Association of Homes and Services for the Aging. The American Association of Homes and Services for the Aging consists of non-profit organizations dedicated to providing housing, health, community and related services for the elderly.

Dr. Dennis Stone is here today representing the California Association of Health Facilities. He serves as executive board member of that association. The California Association is a non-profit organization focusing on improving health care in California. He is also past president of the California Association of Medical Directors.

Then, last, Dr. Paul Willging is executive vice president of the American Health Care Association. The American Health Care Association is a federation of 50 State affiliates representing 11,000 nursing facilities, assisted living, and sub-acute providers nationally. Their focus is on national and State legislative and regulatory policies.

I wonder if somewhere at the end of the table, I could have Dr. Scanlon be at the table as well. Is Dr. Scanlon still here? In the questioning period of time, we may want to ask some questions.

Mr. Hash, we will start with you.

STATEMENT OF MICHAEL HASH, DEPUTY ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION

Mr. HASH. Thank you, Mr. Chairman. Senator Grassley, I want to thank you and the other members of the committee for inviting us to discuss the need to strengthen protections for Americans in nursing homes.

Clearly, as these 2 days of hearings have demonstrated, there are intolerable situations which have occurred and some of our most vulnerable citizens have suffered. This is completely unacceptable. That is why we are taking strong, new action in the Clinton administration to address these problems.

You, Senator Grassley, Senator Breaux, other members of your committee, Senator Kohl and Senator Reid, of Nevada, have provided important leadership in the effort to strengthen the enforcement of nursing home standards and the quality of care for nursing home residents. You have been instrumental in the issues of aging. You have brought focus to the problems of our most frail and to the solution of those problems, and we want to commend you for your leadership.

By working together with you and your committee, we can ensure that nursing home residents receive the highest quality of

care and are treated with the dignity and compassion to which they are entitled. As the President announced last week, we are taking strong, new steps in the area of nursing home enforcement. We will crack down on repeat offenders. We will work to improve State inspection systems. We will work to reduce the prevalence of pressure sores, dehydration, malnutrition, and patient abuse in nursing homes.

We will make sure that egregious violations of the rights or the quality of care of nursing home residents are referred to law enforcement agencies for proper investigation and, if appropriate, for prosecution under Federal civil and criminal statutes. We will post nursing home ratings on the Internet so that they will be widely available to the families of nursing home patients and to individuals who are seeking to evaluate the choice of a nursing home.

We are asking, as you know—and you have been very helpful in this regard—for additional authority for the establishment of a requirement for background checks on individuals who are employed in nursing homes, and also to establish a national registry of individuals who have been convicted of crimes related to services provided to nursing home residents. We want to work with you to make sure that your legislation becomes the law.

We also need legislation to let more types of nursing home employees perform critical nutrition and hydration functions that we have mentioned to you, and we need Congress to reauthorize a strong nursing home ombudsman program through the U.S. Administration on Aging. Finally, we do need authority to collect user fees to pay for inspections that we are carrying out and we need your support to obtain the authority we need to have adequate funding within the Health Care Financing Administration to support this ambitious agenda.

The nursing home regulations that we implemented in 1995, as you know, Senator, are the toughest standards that have ever been put into Federal regulations for nursing homes. There has been, we believe, some improvement in the performance of nursing homes as a result of those 1995 regulations and the 1987 congressional action which established the foundation for those regulations.

As you know, improper use of drugs in the case of psychotropic drugs have been reduced. Proper use of anti-depressant drugs has been increased and restraint use is down. Obviously, these are important steps in the improvement process for the quality of care in nursing homes. But enforcement efforts have focused too much on letting facilities correct problems to avoid sanctions. Far too often, improvements have—as has been demonstrated here in the last 2 days—been fleeting; they have not been sustained. Far too often, follow-up surveys find residents in real danger once again. That is why, as part of our initiative, we intend to impose sanctions immediately, with no grace period, for repeat offenders where there is actual harm or more serious violations to residents in nursing homes.

There has also been uneven enforcement across the States which, of course, do have the primary responsibility for conducting inspections and recommending sanctions. We intend to work with the States to help them improve their effectiveness in carrying out these surveys and in helping them to further appropriately rec-

ommend sanctions that should be imposed on nursing homes that have serious violations.

As President Clinton said last week, if the States don't do enough, if the States are not able to carry out their responsibilities effectively, then we will find someone else who will do the job for us in a more appropriate way.

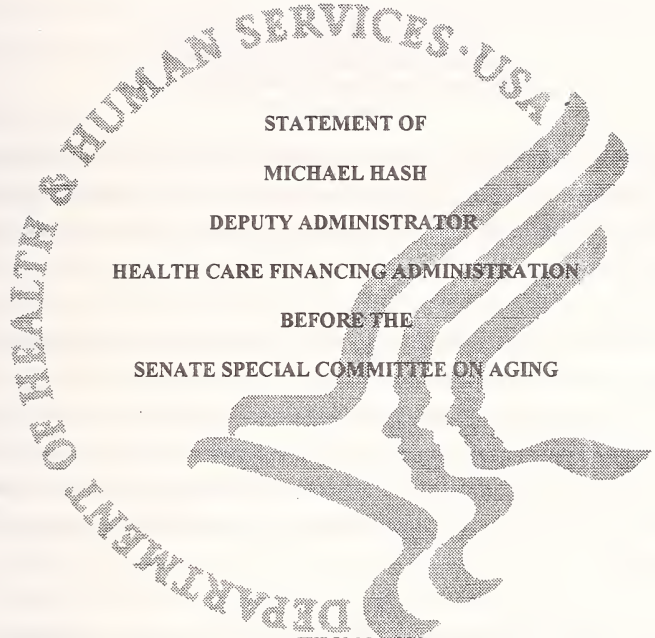
While we have made some progress in addressing the deplorable conditions in nursing homes, clearly we need to take these additional steps. The testimony at this hearing only underscores the urgency with which we need to act. We must and we will address these weaknesses in the State survey and enforcement activities. We will strengthen Federal oversight and we will work with you in the Congress to secure the authority for additional steps that are needed to ensure that we meet our responsibilities.

I am happy at this point to respond to any questions that you might have, Senator Breaux, and we are appreciative of the committee holding these hearings so that these important issues can receive intense public discussion.

Thank you very much.

Senator Breaux [presiding]. Well, we will have questions, obviously, Mr. Hash. Thank you very much. Senator Grassley has had to step out and will be returning shortly.

[The prepared statement of Mr. Hash follows:]



STATEMENT OF

MICHAEL HASH

DEPUTY ADMINISTRATOR

HEALTH CARE FINANCING ADMINISTRATION

BEFORE THE

SENATE SPECIAL COMMITTEE ON AGING

JULY 28, 1998

HCFA
MEDICARE • MEDICAID
Health Care Financing Administration

Testimony of
Michael Hash, Deputy Administrator,
Health Care Financing Administration
before the Senate Special Committee on Aging
July 28, 1998

Senator Grassley, Senator Breaux, Committee members, thank you for inviting us to discuss the need to strengthen assurances that Americans in nursing homes receive high quality care and are treated with dignity and compassion. Clearly, intolerable situations have occurred, and our most vulnerable citizens have suffered.

As the President announced last week, we are taking strong new steps to address what both our own Report to Congress and the General Accounting Office investigation make clear is a serious problem. We can and we will implement many of these new actions on our own now. We also need Congress to give us legislative authority for some additional provisions that will help ensure that we can meet our obligation to protect the very vulnerable Americans who need nursing home care. We want to work with you to make sure that all of these important steps are taken quickly and effectively.

Since 1995, the Administration has been enforcing the toughest nursing home regulations in the history of the Medicare and Medicaid programs. Working with states, who have the primary responsibility for conducting on-site inspections and recommending sanctions, we have sharply increased the number of penalties levied on poor-quality nursing homes. Our new Report to Congress notes improvements in the quality of care delivered in nursing homes as a result of these new regulations. But the report also finds a need for further improvement by states, nursing homes, the federal government, and others.

In our new initiative, we will:

- work with states to improve their nursing home inspection systems;
- crack down on nursing homes that repeatedly violate safety rules;
- require criminal background checks on all new nursing home employees;

- focus on reducing the incidence of bed sores, dehydration, and malnutrition; and
- publish nursing home quality ratings on the Internet.

BACKGROUND

About 1.6 million elderly and disabled people receive care in approximately 16,800 nursing homes across the United States. The federal government, through the Medicare and Medicaid programs, provides funding to the states to conduct on-site inspections of nursing homes participating in Medicare and Medicaid and to recommend sanctions against those homes that are violating health and safety rules. Since 1995, we have had authority to levy harsher penalties on nursing homes found out of compliance with those rules.

That authority was granted to us through the Omnibus Budget Reconciliation Act of 1987, which reformed the way states and the federal government oversee nursing homes and protect the health of residents. The legislation established new standards for quality, a set of resident rights, a new system to assess the quality of nursing home residents' lives, and a new survey mechanism focused on patient outcomes. The law also created new staffing requirements for licensed nurses and new training requirements for nursing assistants and others. And it established new, more flexible enforcement rules and penalties to help identify and punish nursing homes that violate the new rules. On July 1, 1995, the Clinton Administration published new regulations implementing key provisions of the law. Under these regulations, the number of civil monetary penalties rose from zero in 1994 to 430 in FY 1997.

The enforcement system under these regulations focused on giving facilities a chance to correct problems and avoid sanctions. There are many instances in which better care has been the result. However, even when sanctions have been imposed, facilities with serious problems often improve only temporarily, and subsequent surveys find residents in real danger once again.

EVIDENCE OF IMPROVEMENT

According to the new Report to Congress, there is clear evidence that the new regulations are improving the health and safety of nursing home residents. Specifically:

- overuse of anti-psychotics is down. Before reforms were implemented, about 33 percent of residents were receiving these drugs, now just 16 percent are;
- appropriate use of antidepressants is up. Before reforms were implemented, just 12.6 percent of residents were receiving these drugs, now 24.9 percent are;
- use of physical restraints is down, from about 38 percent to under 15 percent;
- use of indwelling urinary catheters is down nearly 30 percent; and
- the number of residents with hearing problems who receive hearing aids is up 30 percent.

NEED FOR FURTHER ACTION

Despite these improvements attributable to the new regulations, the Report to Congress makes clear that several areas require greater attention.

- State-run nursing home inspections are too predictable. Inspection teams frequently appear on Monday mornings and rarely visit on weekends or during evening hours. This allows nursing homes to prepare for inspections.
- Several states have rarely cited nursing homes for substandard care, an indication that their inspections and enforcement may be inadequate.
- Nursing home residents continue to suffer unnecessarily from such clinical problems as bed sores (decubitus ulcers), malnutrition, and dehydration, which are easily prevented .
- Residents continue to experience physical and verbal abuse, neglect, and misappropriation of their property.

NEW ENFORCEMENT ACTIONS

Because of these continuing problems, we are adding new enforcement tools and strengthening federal oversight of nursing home quality and safety standards. Resource needs for these activities are reflected in the fiscal year 1999 budget request currently before the Congress. Our strategy includes several administrative actions that we will implement now using our existing authority. It also includes additional steps that require new legislative authority from Congress.

Our administrative steps will target states with weak inspections. As President Clinton said last week, "If state enforcement agencies don't do enough to monitor nursing home quality, we will cut off their contracts and find someone else who will do the job right."

We will establish tougher inspections everywhere, focus on easily preventable problems like bed sores and malnutrition, combat resident abuse, increase prosecution of egregious violations, publish survey results on the Internet, and continue development of our automated data system to better identify problems and improve quality.

Target States with Weak Inspection Systems.

- We will provide additional training and other assistance to inspectors in states that are not adequately protecting residents.
- We will enhance federal review of the surveys conducted by the states. Standard evaluation protocols will be implemented in every state this fall.
- We will ensure that state surveyors adhere to HCFA's policy to sanction nursing homes with serious violations and prohibit sanctions from being lifted until after an onsite visit has verified compliance.
- We will terminate federal funding for nursing home surveys for states that fail to adequately perform survey functions or fail to improve inadequate survey systems, and instead contract with other entities to conduct nursing home survey and certification activities in those states.

Tougher Nursing Home Inspections.

- We will impose sanctions without a "grace period" for second offenses involving violations that harm residents; until now even serious repeat offenders have been given a chance to correct problems and avoid penalties.
- We will not lift sanctions for serious violations until state inspectors conduct an on-site visit to verify that the problem is fixed.
- We will have state surveyors conduct inspections more often for repeat offenders with serious violations, without decreasing inspection frequency for other facilities.
- We will have state surveyors stagger survey times for all facilities, with a set amount to be done on weekends and evenings.
- We will focus on nursing home chains that have a record of noncompliance with federal rules.

Preventing Bed Sores, Dehydration, and Malnutrition.

- We will step up review of nursing homes' performance in preventing bed sores, dehydration, and malnutrition by increasing resident case reviews in these specific areas during the survey.
- We will sanction nursing homes with patterns of violations.
- We will develop a repository of best practice guidelines for residents at risk of weight loss and dehydration with the Administration on Aging, the American Dietitians Association, clinicians, consumers, and nursing homes.

Combating Resident Abuse.

- We will have state inspectors review each nursing home's system to prevent, identify, and stop physical or verbal abuse, neglect, and misappropriation of resident property.
- We will share information about each nursing home's performance in this area with residents and their families.
- We will recommend that nursing homes inquire about criminal convictions when interviewing applicants for employment.

Prosecution of Egregious Violations.

- We will work with the HHS Inspector General and the Department of Justice to ensure that state survey agencies and others refer appropriate cases to DOJ and/or the OIG where appropriate, for prosecution under federal civil and criminal statutes, particularly cases that result in harm to individual patients.
- We will work with the HHS Inspector General to conduct training for and provide technical assistance to federal survey and certification staff and HCFA contractors on how to make appropriate referrals of such cases to the Inspector General.

Publishing Survey Results on the Internet.

- We will post individual nursing home survey results and violation records on the Internet to increase accountability and flag repeat offenders, as well as superior performers, for both families and the public.

Continuing Development of Minimum Data Sets.

- We will continue development of our national automated data system for information on resident care. We began collecting information on what is known as a Minimum Data Set in June 1998.
- We will analyze this information over time to identify potential areas of unacceptable care in nursing homes, and use it to assess nursing home performance in such areas as avoidable bed sores, loss of mobility, weight loss and use of restraints.
- We will use these assessments to better identify nursing homes for immediate onsite inspections, detect and correct systematic problems early, and improve nursing home quality.

NEW LEGISLATIVE ACTIONS

In addition to the administrative steps described above, we are asking Congress to provide needed authority for several additional actions to help improve nursing home care and safety.

Criminal Background Checks. We need authority to establish a national registry of nursing home employees convicted of abusing residents and to require criminal background checks on all newly hired personnel.

Nutrition and Hydration Therapy. We need to abe able to allow more types of nursing home employees, with proper training, to perform crucial nutrition and hydration functions.

PENDING LEGISLATION

Nursing Home Ombudsman Program. We need Congress to reauthorize a strong nursing home ombudsman program through the U.S. Administration on Aging. Ombudsmen are an excellent source of information about poor-quality nursing homes and abuse or neglect of patients.

User Fees. We need authority, as requested in our FY 1999 budget proposal, to collect a fee from Medicare providers and suppliers requesting participation in Medicare both for initial surveys and for recertification surveys. Fee amounts will reflect the unit cost of a survey and the costs incurred by both state and the federal government to administer the program. The amounts will vary by state, since survey costs vary by state. The fees will be credited to our program management appropriation, with fees for initial surveys paid by each nursing homes when it is surveyed, and fees for recertifications deducted from payments to the nursing home.

PUBLIC VS. PRIVATE ACCREDITATION

Finally, at Congress' request, we also evaluated how private accreditation of nursing homes compares to the current system. We secured an independent evaluation by Abt Associates to assist in that portion of the report. The report concludes that the private Joint Commission on Accreditation of Healthcare Organizations (JCAHO) survey process is not effective in protecting

nursing home residents. JCAHO surveys focuses on structure and process measures, not on whether residents actually get appropriate care. JCAHO surveyors repeatedly miss instances where residents suffer actual harm because of inadequate care. In more than half of 179 cases where both HCFA and JCAHO conducted inspections of the same nursing homes, JCAHO failed to detect serious problems identified by HCFA. Also, the public does not have access to JCAHO survey findings. According to Abt Associates, granting "deeming" authority to JCAHO would place nursing home residents at serious risk. While we have concluded in this report that JCAHO's current approach to the survey process is unacceptable, we would be willing to consider a public/private partnership that would help us target our survey and enforcement efforts on poor performers.

CONCLUSION

We have made some progress in addressing the deplorable conditions and heart wrenching human consequences in America's nursing homes, but clearly we must do more to assure that Americans in nursing homes receive high quality care and are treated with dignity and compassion. The parallel findings of our Report to Congress and General Accounting Office investigation are a clear call to action. Testimony at this hearing underscores the urgency to act now. We must and we will address weaknesses in state survey and enforcement activities. We will strengthen federal oversight. And we will work with Congress to secure authority for additional steps needed to ensure that we at HCFA meet our responsibility for ensuring the quality of nursing home care.

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Senator BREAUX. Next, we will hear from Mr. Sheldon Goldberg. Mr. Goldberg is president of the American Association of Homes and Services for the Aging.

Mr. Goldberg.

STATEMENT OF SHELDON R. GOLDBERG, PRESIDENT, AMERICAN ASSOCIATION OF HOMES AND SERVICES FOR THE AGING

Mr. GOLDBERG. Senator Breaux, Senator Grassley, when he returns, and members of this committee, it is very much of an honor of mine to appear before you. I serve as president of the American Association of Homes and Services for the Aging. Across America, we represent exclusively not-for-profit; provider over 70 percent of the members we represent are affiliated with religious denominations of all types across this country.

There are approximately 1 million people being served by these non-profit organizations and agencies. They represent nursing homes, retirement communities, low- and moderate-income housing programs, as well community-based services and assisted living. They provide a comprehensive system of services.

I have to tell you we are very proud of them. They exist totally to enhance the self-worth of the people they serve. They have improved the physical functioning of the people they serve. They enhance the dignity of these individuals and they have a longstanding commitment.

I represent providers some of which literally pre-date the Constitution of this country. Long before there was a Medicare or a Medicaid or a survey agency, these organizations and religious denominations were committed to meeting people's needs.

We appreciate this opportunity to appear before you on a very important issue and to tell our story and in many ways applaud the committee for the work that has been done here. I respectfully request that our remarks be part of the record, that our written statement be part of the record, and because we had very limited time to review the GAO report, that the record stay open in case there are additional comments we may wish to make to the committee.

I have to start off by saying that I believe that the majority of nursing homes, and the majority of people and staff who work in those nursing homes, seek to provide good care. I think there are people who come to it with commitment. There are people who have limited resources sometimes by which to operate, but their goal is to meet the people's needs.

I further believe that the implementation of OBRA 1987 has had a desirable impact on the quality and the lives of people within nursing homes. I saw a recent study from the Research Triangle Institute that suggests that because of improved nursing home care, there are 26 percent fewer hospitalizations, resulting in less utilization of Medicare. The study also counteracted some of the allegations being made here, showing that the majority of facilities are helping to maintain individuals functioning far better than they did in the past.

But I cannot dispute some of the findings in the GAO report. Whether there is one instance of abuse or neglect or many, that is

too many. It is imperative that we find ways of getting rid of the bad apples, getting rid of the providers who consistently do not meet the needs of their residents. Facilities providing abysmal care need to be closed. They need to find new owners, new operators, people who will consistently meet the needs of people they are supposed to serve. If that can happen as a result of this hearing and these discussions, then certainly the work of the GAO, and especially this committee, was very, very worthwhile.

Those who are providers, those who run the State agencies, and those at HCFA know the worst of the worst facilities, and it is time for us to direct attention from all sides to removing them from the industry as soon as possible.

I have to tell you candidly that one of the recommendations which we have made to this committee and to the GAO very early on stems from the fact that there is little attention being provided to some of the people and organizations which tend to get into this field. We pay a lot of attention to licensing and certifying homes for Medicare and Medicaid. But, unfortunately, as some new provider comes to the field. We pay very little attention to their past record, their past ability to provide service, and the past experiences that they have had with resident care.

We believe that for those providers, in the same State or other States, that have established a record that is not acceptable in terms of the quality of care, questions should be raised before they are allowed to acquire, buy, purchase, or move back into this field if they have not established a record of providing quality care. At least, that record needs to be looked at before those providers. The ability to expand and grow should be an honor and should be bestowed on those who do the best job in terms of meeting the needs of the elderly in our country.

OBRA 1987, which was passed by earlier Congresses, established a very high standard and a very good standard. Part of that standard is to provide and assure that each resident receives the necessary care and services to attain and maintain his or her highest practical physical, mental and psycho-social well-being. We think that is the appropriate standard and is one upon which I don't think we can improve.

But what we can improve upon is the efficiency and the effectiveness of the enforcement system as it rids us of the worst and poorest performers in the system. We believe that the frequency of surveys for poor performers should be increased. It should not be once a year; it should be more often. We believe that an appropriate recommendation is to survey facilities during non-traditional hours. Come in the evening, come on the weekend, come whenever, especially for those providers who establish themselves as not providing appropriate levels of care.

We recognize that State survey agencies, like all of us, have limited resources. We would strongly suggest that you target those resources to the home that everyone knows is out there, the one providing the poorest care. By spreading out the resources better to go after the homes that are consistently in violation, you will need smaller teams and simply provide more frequent visits to those facilities who consistently are out of compliance.

But at the same time, because there are short resources, we think it makes very little sense that all nursing homes, whether good or out-of-compliance, should receive the same survey treatment. Those who establish good behavior, reward them, recognize them, and come less frequently. Those who are poor performers, spend more time and more resources to rid them from this industry or to bring them into full compliance.

I would like to talk very briefly, about a couple of other points—I know time certainly is limited today—and that is on the staffing shortages which we face. These are not new. They are somewhat exaggerated today because of the power of the economy. We are finding staffing to be increasingly more difficult, but I am very proud of the non-profits in this country because we tend to staff higher. In national averages, we tend to have more RNs, we tend to have more LPNs, we tend to have more staff on the care side.

We also, on the opposite side, tend to have less administrative staff. This has been documented quite regularly. But we are all whether non-profit or for-profit, feeling the difficulties of training and retaining the staff in our nursing homes. When we finally get them trained and we provide those training resources, we find very quickly, because of inadequacies of reimbursement, those staff leave us. They go to hospitals, they go to other environments, they go to McDonald's, where they can sometimes get higher wages and better benefits.

That is not necessarily a function of our unwillingness to pay. It sometimes is a function of the inadequacy of reimbursement systems to meet the needs of the staff within our community. Obviously, these people deserve fair wages and compensation, and this is something that has to be recognized by the reimbursement systems in this country.

Now, let me end with one last point that is perhaps most important. It is very easy to point the finger and say that the problems can be fixed by the survey and certification process. However to do so misses the real complexity of this issue. The survey and certification process is one very important point to look at, but the blame extends to everybody.

Some of the blame lies at the Federal level. It lies at the State level, it lies at the local level, and it lies within our communities where people are unwilling to get involved and go visit and see. Sometimes when residents are placed in nursing homes, they literally end being parted from the community. It is very important that in the survey process we not only look at the quality of the homes, but that we also start looking at public policy issues to refocus and re-fuse the nursing home back in the community for example, how do we begin to provide a sufficient supply of nursing home beds in the appropriate geographical areas so that residents can be close to their family members, so they can visit early and often and easily? How do we begin to evolve and make decisions about who owns these facilities? How do we begin to look at the past records of care, and why do we sometimes reward those who do the worst job with the ability to buy more and more nursing homes and perpetuate their problems in other places simply because they have capital.

We have created a system in this country that sometimes yields absentee ownership. It used to be that the nursing home was very much an integral part of the community. Perhaps some of the policies that are being advanced at both the State and the Federal level relative to reimbursement through Medicare and Medicaid contribute to the separation of nursing homes from the community. PPS is a classic example of this trend. Wall Street just said this is a very clear indication that the nursing home industry has to go through further consolidation to survive economically.

I have some concerns with further consolidation of this industry. It removes decisionmaking from the community. It removes boards of directors and people from becoming involved and impacting decisionmaking, and I think it removes people from being an integral part of the care that is going to the loved ones within their community.

In closing is it important to take the GAO report seriously? Absolutely. It is a serious report. We honor it, we appreciate it coming forward and we all should look at it very carefully. Obviously, we have to pay close attention, but we cannot generalize to say that all nursing homes are bad, or to say that all State survey agencies are having problems, or specifically that all problems are within the State of California.

I am concerned with one problem that may emanate from this hearing that will not be positive. I worry that we will set up the standard that the only evidence that a surveyor or a survey agency is doing a good job is that they cite a high number of deficiencies and collect large fines. With such a standard, you will find that homes that are good will oftentimes be cited for deficiencies that are not fair.

I have to tell you if those homes are forced to defend themselves and fight unjusted citation unfortunately all we are going to be doing is tying the surveyor up with all kinds of red tape and involvement with courts. We will have created a scenario in which surveyors have to cite more violations to prove that they are doing a good job. My hope is that we can begin to target the resources to those homes we know are not doing a good job, and that we can reward those homes that are doing a good job by encouraging them to do better.

I very much appreciate the work of this committee. Senator Grassley, I appreciate your personal leadership—I know of your commitment to this area. Thank you for allowing us to share our views with you today.

Thank you very much.

[The prepared statement of Mr. Goldberg follows:]

STATEMENT OF

SHELDON L. GOLDBERG
PRESIDENT

AMERICAN ASSOCIATION OF HOMES AND SERVICES FOR THE AGING

BEFORE THE:

UNITED STATES SENATE
SPECIAL COMMITTEE ON AGING

on the Report of the General Accounting Office

concerning the Quality of Care in California Nursing Homes

July 28, 1998

On behalf of the American Association of Homes and Services for the Aging (AAHSA) we are pleased to present testimony that addresses quality concerns in California's nursing facilities. We commend Senator Grassley and his colleagues on the Senate Special Committee on Aging for their continuing attention to the needs of the elderly, and particularly those in nursing homes. The issues presented by the report of the Government Accounting Office, which is the subject of this hearing, point out that we are not there yet in our efforts to guarantee quality care to every nursing home resident. We welcome the opportunity to provide input and comments to the Committee about how we reach that goal together.

AAHSA is a national non-profit organization representing more than 5,000 not-for-profit nursing facilities, continuing care retirement communities, senior housing facilities, assisted living and community-based organizations. More than half of AAHSA's membership is affiliated with religious organizations; the remaining members are sponsored by private foundations, fraternal organizations, government agencies, unions, and community groups. With our broad range of facilities and services, AAHSA members serve more than one million older persons daily. For the past thirty-six years, AAHSA has been an advocate for the elderly and for a long-term care delivery system that assures all those in need of high quality services and quality of life. Our membership has a long-standing commitment to meeting the needs of the individuals we serve in a manner that enhances their sense of self-worth and dignity.

The GAO report which is the subject of this hearing was prepared to look at the question of whether serious quality problems exist in some California nursing homes. Based on what it acknowledges was a small sample, GAO did document a number of problematic situations. However, AAHSA believes that any broad-brush portrayal of long-term care, or even of the long-term care regulatory system, from this sample would be misrepresentative. For that reason, AAHSA would like to provide a context from which to view the GAO findings.

Additionally, we would like to point out to the Committee that we had an opportunity [under somewhat restrictive conditions] to briefly review the GAO's findings. AAHSA staff was allowed to read the report at GAO offices here in Washington, D.C. We were not premitted to retain copies of the report or notes of our observations. We did provide some initial reactions and comments to staff of the GAO based on this initial reading.

Senator Grassley, in your invitation letter to testify before the Special Committee, you asked that we address the findings of the GAO study. Obviously, a thorough treatment of the major findings and recommendations of the report is most difficult considering the conditions imposed on us. We respectfully request that the Committee give us the opportunity to add to and/or amend this written testimony after we have a chance to more completely study and evaluate the report.

OBRA '87 and Current Regulation of Nursing Facilities

The nursing home quality reform provisions of the Omnibus Budget Reconciliation Act of 1987 (OBRA '87) enacted the most sweeping changes to nursing facility operations since the passage of Medicare and Medicaid. AAHSA strongly supported the passage and implementation of OBRA. We were one of the initial members of the Campaign for Quality Care, the coalition of organizations coordinated by the National Citizens' Coalition for Nursing Home Reform (NCCNHR), that worked to reach consensus on twelve key areas of nursing home reform. AAHSA has continued to serve on various committees and workgroups convened by the Health Care Financing Administration to work toward a reasonable and equitable implementation of the regulations and interpretive guidance resulting from the OBRA requirements. We are currently working with HCFA on the agency's most recent long term care initiative, *Sharing Innovations in Quality,* an effort to establish an easily accessed central repository for innovative practices in long term care. As a national association we have remained an advocate for the presence of federal standards because we believe that many of the policies and care practices of our members have been enhanced as a result of these provisions.

One of the most significant transformations resulting from the passage of OBRA '87 was the shift in focus of regulatory oversight from facilities' capacity to provide care, "paper compliance" with requirements, to one on resident outcomes, that is, the actual care provided.

Several of the nursing home quality reform provisions and resulting federal regulations have facilitated this change in approach and have worked to improve the quality of care and assure better resident outcomes.

1. Standardized Resident Assessment (RAI/MDS)

Central to the OBRA '87 change from process to outcomes is the mandate that every facility conduct "...initially and periodically, a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity." These assessments are to be interdisciplinary in nature, to be conducted at least annually, reviewed quarterly, and revised in the event of a significant change in status. The resident assessment instrument and minimum data set (RAI/MDS) developed under the auspices of the Health Care Financing Administration (HCFA) as a result of OBRA '87 has been successfully implemented on a national basis and has been revised (MDS 2.0) to provide further clarification and increase its clinical effectiveness.

Included in the 18 domains that comprise the RAI/MDS is a section assessing oral and nutritional status. This section is intended to identify specific problems, conditions, and risk factors related to malnutrition. As with the other areas of assessment, those residents identified through the MDS as being at risk for nutrition related problems, including the problem of pressure sores identified in the GAO report, are subject to a more in-depth evaluation to identify reversible or treatable causes of these problems. The results of this assessment process provide the basic guidance for the development of a care plan.

As of June 22, 1998, the MDS data collection and transmission process has been computerized through a nationwide system. HCFA now is implementing a national database to serve as a repository for this information. This database will allow HCFA to compile individual resident profiles, to link individual assessments longitudinally, and to monitor outcomes in terms of both improvement and decline. It will also be used to develop performance standard norms or "quality indicators." The ability to track individual and collective resident outcomes on a longitudinal basis will permit the Administration to target its oversight resources on facilities providing less than optimal care. With its planned "feedback loop" to providers, the MDS database also has the potential to serve as an effective internal quality assurance and management tool for long term care facilities. When the database is fully functional, both providers and regulators alike will be able to spot the problem areas identified by GAO more readily.

2. Highest Practicable Physical, Mental, and Psychosocial Well-being

OBRA '87 also placed nursing facilities in the unique position of being the only health care provider to be mandated to guarantee specific resident or patient outcomes. Under requirements for both Resident Assessment (CFR 483.20) and Quality of Care (CFR 483.25), nursing facilities must "provide and assure that each resident receives the necessary care and services to attain and maintain [his/her] highest practicable physical, mental, and psychosocial well-being." The interpretive guidelines for these requirements (HCFA State Operations Manual Transmittal #274) state that "Facilities must ensure that each resident obtains optimal improvement or does not deteriorate [within the limits of the resident's right to refuse treatment, and within the limits of recognized pathology and the normal aging process]."

This language not only assures that resident outcomes will be stressed as a measure of quality of care, but also places a clear responsibility on nursing facilities not just to maintain the status quo, but to act aggressively to improve the resident's health status.

3. Staffing requirements

OBRA '87 eliminated the prior staffing distinction that existed between intermediate care facilities (ICFs) and skilled nursing facilities (SNFs). This means that all nursing facilities are now required to have twenty-four hour licensed nursing staff and a registered nurse for at least eight hours a day, seven days a week.

In keeping with the statutory intent to focus on outcomes rather than process, the current Requirements for Participation for Long Term Care Facilities, promulgated as a result of OBRA '87, do not mandate staffing ratios, but require that facilities have "sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident...."

In developing the nursing home quality of care provisions, Congress also recognized the magnitude of care provided by nurse aides. Nurse aides employed by facilities are required to meet minimum training and competency evaluation requirements. Facilities are prohibited from using any individual as a nurse aide for more than four months on a full-time basis, unless that individual has successfully completed at least a 75-hour training and competency evaluation program, (NAT/CEP) or a competency evaluation program, approved by the State.

Outcomes vs. Staffing Ratios

From time to time the suggestion has been made that OBRA '87 be amended to establish specific nursing care staffing ratios for nursing facilities. Even though not-for-profit facilities traditionally staff at higher levels,[1] AAHSA would strongly oppose such an approach for several reasons.

First, both the provider and consumer communities have long supported the shift from process to outcomes as a means of assessing quality of care. Any attempt to assure the provision of optimal care based on mandated nursing care staffing ratios would defeat all of the efforts that have been made within both the legislative and regulatory arenas to achieve this goal. Additionally, any assumptions of quality based on numbers of nursing care staff and nursing hours rather than on efficient use of nursing care staff and resident outcomes is simplistic and potentially deceptive.

Second, while too little staffing will certainly lead to poor outcomes, there has never been any proven correlation between higher staffing levels and the guarantee of positive outcomes.

Third, inherent in any mandate for staffing ratios is the danger that the minimum will become the maximum. This scenario is even more likely in the managed care environment and the accompanying climate of cost containment.

Finally, a mandate for staffing ratios discounts the growing role of technology in nursing facilities. One example that can be cited from the past is the Hoyer Lift. Prior to its development, two nurses or nurse aides would be needed to lift one resident. With the Hoyer lift, this task can be performed by one nurse or aide, cutting the number of required staff by half. The raises the question whether staffing ratios would have to be recalculated every time a new mode of technology is developed that can substitute for, and possibly perform better than, human intervention.

OBRA '87 and the Federal regulatory system already assure adequate protection for residents through requirements that facilities have the appropriate level of staff to enable residents to function at their highest practicable level. Failure to comply with these requirements subjects nursing facilities to State and Federal enforcement actions. Any further specification of staffing numbers or ratios would be excessive and would undermine the focus on resident outcomes as an effective barometer of care.

[1] Based on all staffing categories reported by the 1995 National Nursing Home Survey, National Center for Health Statistics, Advance Data No. 280, Table 8, January 23, 1997.

The existing regulatory system for ensuring quality in nursing home care contains all of the tools that the federal and state governments need to make sure that nursing facilities are staffed appropriately. Rather than prescribing arbitrary and inflexible staff ratios, the existing regulations mandate favorable outcomes for nursing facility residents, and that each resident reach and maintain his or her highest practicable physical, mental, and psychosocial well-being. This requirement constitutes a higher standard of care than staffing ratios would be likely to achieve. It is the standard by which nursing facilities already are being evaluated, and we believe that facilities should continue to be held to this standard.

Nurse Aide Shortage

AAHSA firmly believes that mandated staffing patterns numbers are contrary to an outcomes-based assessment of care. However, we do not dismiss the argument that a poor resident outcome can result from a shortage of staff, particularly nurse aides. The GAO report suggests that short staffing may have contributed to some of the problems cited.

We acknowledge that one of the key challenges faced by nursing facilities is the ongoing shortage of nurse aides - a shortage that has been exacerbated in recent years by the downsizing of professional staff and increased use of paraprofessionals in acute care, as well as the growth in demand for aides in home health care. Because of the competency evaluation and certification associated with the NATCEP, it has become increasingly attractive for providers from other care settings to recruit and hire nurse aides trained and certified under the requirements for nursing facilities.

While nursing facilities have been working to enhance the functions of the nurse aide, including greater development of career ladders, home health agencies and hospitals are frequently able to offer greater flexibility in scheduling and/or higher wages. The result is that aides are being trained and certified in nursing facilities, and then moving on to apply their skills in other settings. Thus, while higher acuity levels among nursing facility residents, as well as projected aging demographics, point to a demand for paraprofessional staff in nursing facilities that will continue to escalate, nursing facilities find themselves in the untenable position of seeking to fill these positions from an already limited labor pool that is currently being drained by acute and home care providers. Given the status of state and federal payments to nursing homes, our ability to compete with hospitals and home health agencies is minimal. The irony, of course, is that long-term care--arguably the most poorly-funded component of the health system--is actually subsidizing those providers which are not required to bear the cost of training their personnel, as are we.

Specialized Training

AAHSA has proactively worked to alleviate the shortage of nurse aides and has developed a proposal to respond to this issue under some limited circumstances. As stated above, nurse aides are subject to mandated training requirements and competency evaluaiton. In the nursing home environment, many employees who are neither nurse aides nor licensed health professionals also have frequent and regular contact with residents, either by personal choice or as an integral part of their job. Permitting

these individuals to perform tasks determined to be non-nursing-related may offer some relief to the nurse aide shortage without compromising the health and well-being of the resident.

Three areas of potential non-nursing employee assistance have been identified. Assistance with eating is probably the most frequently cited, but others include transporting and mobility, and activities.

Allowing non-nursing employees to provide assistance would be based on the needs and potential risks to the individual, as identified in the comprehensive assessment and determined by the licensed nurse responsible for the resident. For example, assisting a resident with a swallowing problem to eat would be considered nursing-related, while helping an alert and competent resident with a paralyzed or immobilized arm would not. Personnel performing non-nursing-related tasks would be required to complete relevant in-service training approved by the regulatory authority and demonstrate competence in the duties assigned.

AAHSA has developed legislative language to permit delegation of non-nursing tasks. A copy of our proposal is attached.

4. Reimbursement

Most nursing facilities and their residents are heavily dependent on the Medicaid program, which pays for over half of the total cost of nursing home care nationwide. Medicare covers relatively little long-term care, and few nursing home residents have private insurance that covers the cost of their care. Residents who have any financial resources pay for their nursing home care out of pocket. Once their resources are exhausted, they qualify for Medicaid coverage.

Medicaid reimbursement rates for nursing facilities often are not set according to the cost of providing care, but according to what the state feels it can afford. Medicaid rates therefore are often substantially below actual costs. Although AAHSA would never argue that high rates automatically result in high quality, few could dispute that dismal payments eventually result in unsatisfactory care. For the record, we note that California ranks 46th of the 50 states in nursing home Medicaid expenditures per capita[2]—this in a state that ranks 12th in personal income[3]. California has clearly made a decision that long-term care is not a high priority.

This problem will be exacerbated by the repeal of the Boren Amendment under the Balanced Budget Act. The Boren Amendment used to require that Medicaid reimbursement bear a reasonable relationship to the actual cost of efficient and effective care in a nursing facility. Facilities had recourse to the courts if reimbursement levels fell too low, and the fact that facilities frequently prevailed in these cases indicates how often states have tried to cut corners on nursing home reimbursement because of other budget priorities.

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[2] American Association of Retired Persons, Across the States 1998, Profiles of Long-Term Care Systems, 3rd edition. Based on 1996 data.

[3] Based on 1995 data reported by the Bureau of the Census in Statistical Abstract of the United States, 1996, 116th Edition.

We stated earlier that many of the problems cited by the GAO report can be attributed to staffing issues. Nursing facilities cannot retain qualified staff unless we can pay them decent wages and benefits. It seems as though governments at all levels care about nursing home residents right up until it becomes time to pay for their care, and then state autonomy and balancing the budget are given greater weight. Without the Boren Amendment, nursing facilities have little leverage to bargain with the states on reimbursement rates. We urge you to give renewed attention to this issue as you continue to examine the quality of care in nursing facilities. The Balanced Budget Act and its Medicare payment "reforms" add a whole new layer of reimbursement concerns for nursing homes which must be addressed as well. A prospective payment system that will take more than $12 billion out of Medicare SNF payments, new requirements for consolidated billing, and excessively stringent caps on therapies present frightening scenarios for the funding of long-term care.

Impact of OBRA '87

The purpose of the GAO study was to document the existence of bad care and instances where the system's response was inadequate or inappropriate, and it did so. The draft report also notes the limitations of this study and warns about generalizations to all facilities. It is therefore equally important to remember that there is another—positive—side to this story, and much of what is happening in nursing homes does not reflect the failure of the current system, but rather its success.

Since the implementation of OBRA '87 and the resulting federal regulations, several studies have found significant improvements in quality of care and resident outcomes in nursing facilities, including reductions in the use of psychotropic drugs and physical restraints. A 1995 study funded by the Health Care Financing Administration found significant reductions in decline [and need for assistance] among residents in activities of daily living, such as bathing, dressing, locomotion, toileting, transferring, and eating. The study also found a 26% decrease in hospitalizations among nursing home residents. This reduction reflects not only increased resident well-being, but also a positive impact on Medicare expenditures, yielding an estimated savings to the Medicare program in hospital costs alone of more than $2 billion per year in 1992 dollars.

In addition to the contributions made by OBRA '87, many voluntary innovations in quality are on-going, as referenced earlier. Providers also are excited about ways to measure resident satisfaction with care. This spring we asked our members to send us copies of resident satisfaction instruments they currently are using. In a two-week period, we received 700 samples.

Yet, as GAO points out, even though state and federal enforcers have the tools they need to monitor care and respond to deficient care practices, we still see reports of bad conditions, such as avoidable malnourishment or pressure sores, in some nursing facilities. Rather than new laws or regulations to add to the already elaborate structure governing nursing facilities, we agree with GAO that these incidents indicate a need to restructure or refocus the long term care survey and enforcement process.

We would also like to take the opportunity to correct what we believe was a misunderstanding expressed by GAO in its report.

In the report, the GAO refers to "amnesty" afforded to facilities under federal law once deficiencies are corrected, in the form of "forgiving" the noncompliance once correction is achieved. "Amnesty" is an inaccurate characterization of this process.

It is true that under current law that facilities with a good compliance history are given the opportunity to correct deficiencies within a given timeframe and defer imposition of a recommended sanction. A good compliance history is defined as no determinations of substandard quality of care within the current or previous two surveys. This deferral of a remedy is consistent with the intent of the law—to promote and support sustained compliance—rather than simply punishing facilities found to have a deficient care practice. It should be made very clear, however, that deferral of a sanction does NOT negate or remove the deficiency citation. Failure to correct the violation results in imposition of the remedy. A repeat violation in this same or a related area on any subsequent survey will result in incrementally more severe civil monetary penalties and/or other available alternative remedies. This is not "amnesty" or "forgiveness" of the deficient practice or of the violation itself.

There are federal criteria for identifying those homes which do have a history of chronic or repeated noncompliance or which have provided substandard care as "poor performing facilities." These facilities do NOT have the "opportunity to correct" and are subject to the imposition of sanctions regardless of how quickly they come back into compliance. Under the law, failure to come into compliance within six months under any circumstance results in automatic termination from the Medicare and Medicaid programs. This process exemplifies the tools the system has available to respond to chronic or egregious noncompliance through the imposition of remedies in accordance with the scope and severity of the noncompliance.

Regulatory System Improvements

OBRA '87 mandates that all nursing facilities be surveyed on an annual cycle ranging from nine to fifteen months, with an average of twelve months. Surveys are an extremely time-consuming process for both nursing facilities and for the state surveyors, as they should be. Since all facilities must be surveyed within the confines of this timeframe, surveyors do not have the opportunity to focus their time and resources on the problem facilities that need more attention. Surveyors must spend as much time in facilities with a consistently deficiency-free record as they spend in facilities where the quality of care has been consistently poor.

Federal and state resources for surveying nursing facilities are not unlimited. The 1998 appropriations for the Department of Health and Human Services cut funding for these surveys by $4 million below the 1997 spending level. We do not expect any significant increase under the 1999 appropriations.

In recognition of the need to target more time and resources to problem facilities, the Health Care Financing Administration in 1996 began an attempt to streamline, without diluting, the long-term

care survey process. While this initiative was squashed, we feel that it was a realistic effort to put more resources into dealing with facilities that have a history of providing poor care.

The nine- to fifteen-month range that OBRA '87 provided for survey cycles indicates a congressional intent to give surveyors some flexibility to inspect nursing facilities with differing frequency. AAHSA feels that the oversight process would be made much more effective if this flexibility were expanded to enable surveyors to inspect facilities with good records at intervals of up to two years. This expanded survey cycle would give surveyors the true flexibility they need to concentrate their time and attention on the facilities with records of poor care so that bad conditions are corrected and consistently bad facilities are shut down.

Conclusion

Based on our brief initial review of the report, we understand that the General Accounting Office made four recommendations, all of which AAHSA can support:

First, GAO recommends that the survey cycle be staggered so that nursing homes cannot predict the scheduling of surveys. The GAO also suggested that surveys be broken down into stages and conducted at different times during the 12-15 month period. Thus, the survey team might examine patient records during one visit, and physical plant during another. This procedure would prevent homes from making improvements only when they thought surveyors were coming.

Second, GAO recommended that surveys inspect a random, stratified sample of resident records rather than the current targeted sample in order to get a better handle on deficiencies in each patient care area.

A third recommendation of GAO was the imposition of penalties for chronically poor performing facilities or for homes with a consistent substandard quality of care.

Fourth, GAO recommended that there be a revisit by HCFA or the State Survey agency after a substandard survey finding -- rather than simply allowing facilities to certify that they are back in compliance.

To these recommendations, AAHSA would add three others. First, we repeat our suggestion that surveyors be given the flexibility to extend the survey cycle for 24 months for good homes so that they can focus on rehabilitating or closing chronically bad facilities. In the past, some have argued against closing bad homes because of transfer trauma to residents who must be moved. We submit that almost no amount of transfer trauma approaches the pain of a Stage IV pressure sore. It's time to get the bad actors out, Mr. Chairman. We might disagree from time to time about which homes are the bad ones, but all surveyors know which ones are the worst. Let's start with those.

Our second recommendation is that government agencies start paying more attention to which facilities are initially licensed by the state and then certified for participation in Medicare and Medicaid. There is no reason to believe that multi-facility providers who give poor care in another

state, or in another part of the same state, will give stellar care in a different facility. Data on nursing home performance is public. It is most certainly available to those who license or certify facilities. Requiring that a sponsor or investor provide **consistently** good care in order to expand its operations is a powerful incentive.

Last, Mr. Chairman, we believe it is time for a serious dialogue between the Congress, federal and state government agencies, residents and families, and providers about quality. OBRA '87 passed almost 11 years ago, and the new enforcement system has been up and running since 1995, but we are still arguing about whether we have enough regulations to promote good care. GAO has identified both providers and surveyors which appear to be guilty of poor performance. If GAO is correct in its assumption that the problems may be more extensive than its California examples, then we have a mutual problem. It is a problem that must be addressed, Senator. We believe that long-term care is going to be a more important part of the future health care system than anyone ever imagined it would be. We all must be prepared for that.

The situation as we see it was perhaps best captured by Msgr. Charles J. Fahey, director of the Third Age Center of Fordham University in New York, in a paper on the ethical issues presented by the Balanced Budget Act.[4] Msgr. Fahey stated,

> We are a nation in denial. Decreasing mortality has the unintended but real secondary effect of increasing frailty in every age cohort, not just those at the end of life. Costly compensations must be made if those who have handicapping conditions, whatever the etiology or manifestation, are to have decency. Costs, monetary, psychological and or opportunity will be paid by someone. Who will pay the price of "development?" Currently most of the costs are incurred by the user and his and her family, though much is absorbed by providers.
>
> Long term care...has ceased to be on the policy agenda save as a cost cutting issue.

Mr. Chairman, we are asking that you put long-term care back on the policy agenda, and not just as a cost cutting issue.

Again, we thank you for this opportunity to share our views.

[4] "New Funding Patterns in Long Term Care: Ethical Challenges to the Provider Community, July 1998.

The CHAIRMAN. Thank you, Mr. Goldberg.
Dr. Stone.

STATEMENT OF DENNIS STONE, M.D., ON BEHALF OF THE CALIFORNIA ASSOCIATION OF HEALTH FACILITIES

Dr. Stone. Mr. Chairman and members, my name is Dennis Stone and I am speaking on behalf of the California Association of Health Facilities. I am speaking on their behalf, but I think you had it incorrectly up there as far as me being on their board.

The CHAIRMAN. Yes, I did have that, but if it is incorrect, we will correct the record.

Dr. STONE. Thank you. I am just asked to speak from a physician's point of view and on behalf of CAHF. CAHF's membership is comprised of more than 1,450 licensed long-term care facilities in California which serve a wide spectrum of health care needs in different settings, from skilled nursing to intermediate care to subacute care, mental health, rehabilitation, and residential care, and also has providers of services for persons with developmental disabilities.

Nearly 100,000 trained medical and professional support service staff care for 200,000 Californians residing in member facilities each year. CAHF is affiliated with the Quality Care Health Foundation, the Council of Long-Term Care Nurses of California, and the American Health Care Association.

Just a point about my credentials. Besides being a certified medical director and also having an MBA in health services management and being a corporate medical director in the past for Beverly Health and Rehabilitation, I think the thing that helps me speak most toward the quality of care in nursing homes is I started at age 16 working in nursing homes. I used to pass juice in a nursing home before we came up with the term "nourishment." So I have been in the trenches for a very long time and understand how things have changed and have not changed in that quality of care.

Health care providers, in general, of course, really don't condone poor health care and poor quality of care. The ones that do should not be allowed to be continuing in business. I am frustrated, however, that once again we turn to the issue of quality of care in California nursing homes as it is being addressed using data that may be misleading and isn't fully fleshed out in what it can and can't mean.

One of the problems we do have with the survey process we have now in place is that, yes, it is a very good survey tool. It is the outcome of what we developed with OBRA. But as we developed OBRA and that survey, we moved more toward the psycho-social aspects of the survey process and not the medical aspects of the survey process.

So in Dr. Kramer's drill-down studies, he is turning more again back to the medical sides of this that we should be looking at. We should look at those parts of the survey process being expanded. Yes, the psycho-social aspects that we have in place are well and good, but do they truly have the effect on outcome that the medical aspects of it may be?

Care of the aged is an extremely complex area, complicated by the normal aging process, the rights of the patient to forgo treat-

ment, and the lack of specific approaches and expected outcomes that can be considered the standards for this population. Care issues such as incontinence, which can include urge incontinence, overflow incontinence, stress incontinence and functional incontinence—they are all different kinds of process. Each one of them has a different cause. Some of them are totally unavoidable. A good percentage of the patients in nursing homes are there because they are incontinent.

So when we list on the board the problems of the nursing home patient and we equate incontinency as a problem in care, it is truly not. It is a problem that the patient has that we are there to help—not fix it, because we cannot necessarily fix it, but help them address it and make life better for them with that problem. Essentially, with incontinency, you can't teach a demented patient to use their all buzzer to tell the nurses aide that they need to come to the bathroom. So it is something where we have to look at what are the disease processes we are dealing with and how do we go on from there.

Geriatric medicine and the care of the geriatric patient is still essentially in its infancy because we are dealing with a population that truly is in the nursing home because no other part of the health care system has been able to fix it. I have actually addressed the Relative Value Updates Committee of the AMA where we have all the specialties of medicine represented at the table, and I said basically our patients are the ones that you have not been successful caring for, and that is the level of complexity that we are dealing with on a daily basis.

You can't mislabel normal aging as a disease. It is its own process. It has its own physiological changes. There is a risk of assuming that a negative outcome is due to poor intervention. There is no one simple cookbook approach to treat patients who have the identified effects of aging, with their multiple chronic diseases and the multiple medications we have to give them to address those problems.

Additionally, 50 percent of the patients in the nursing homes in California have dementia or a mental illness, and 40 to 50 percent have significant need for assistance in their activities of daily living. Many also have exercised their right to forgo end-of-life interventions. This leads to an entirely different set of care challenges that we address on a daily basis.

There is no question that malnutrition in the aged is a problem. Studies have estimated occurrence of malnutrition as 50 percent in the population, in general, in the hospital in this age group, and 40 percent in the nursing homes. Other studies have shown that 54 percent of the patients admitted to the nursing homes have malnourishment.

But what is malnourishment? What is our definition? Is it body weight versus the body area? When you are dealing with an 85-year-old person, all bets are off. You are dealing with a whole other set of what is the norm for this patient. Ideal body weight of a 95-year-old is sort of irrelevant.

A classic example, just another part of the study on that—I had a patient who was 106 that I ran an electrocardiogram on. The electrocardiogram was assessed by the computer and the computer

came back, "patient has an electrocardiogram abnormal for this age." I am thinking, how many other electrocardiograms do they have on 106-year-old patients to even look at? So what we are dealing with are problems that you need to individualize.

Things that can cause malnutrition include refusal to eat, depression, decline in taste and smell, difficulty chewing, difficulty swallowing, digestive problems, constipation, and malabsorption. Any one of these things can be a variable, and I have to assure you that, in general, everyday the nursing staff and the nurses aides are addressing those problems. They use every trick in the book, quite honestly, to try to get their patients to eat. Yes, staffing is an issue, but with the time that they have available, that is their agenda to keep that patient fed and clothed and clean.

I believe that there are some other measures which need to be taken to ensure that the quality of care issues are identified and appropriately addressed in California. One thing we need to look at is patient acuity levels which continue to rise in our State, and this is simply because we, by policy, through DRGs, move patients who used to be in our acute care facilities and move them down into our skilled and sub-acute and regular facilities.

You look at a nursing home in California where there is an extremely high penetration of managed care and you look at a nursing home in other parts of the country, and there is significant difference. One of them looks a lot like a hospital. One of them still looks more like a regular, classic nursing home of 20 years ago.

It was interesting. We had, actually, an argument in the American Medical Directors Association where some of the physicians were saying, why should I have to visit these patients frequently, and they thought frequently was every 30 days. And it turned out that they were in States where intermediate care had been blended into skilled care, and so they had a lot of much more functional, much more ambulatory patients as part of their patient profile and they were not seeing the level of acuity we were seeing in California.

Increased funding is also needed for necessary research and demonstration projects to identify and quantify care of the aged, to develop a more effective monitoring system, and to revise the punitive nature of regulation. We should be using management of this time; we shouldn't be using punitive management, we should be using facilitative management.

The concept of best practice long ago started to be implemented by California providers, and quality improvement programs are in much need of more attention. CAHF has always supported research in these efforts and many of its members have participated in much-needed research done by UC, Andrus, and the RAND Corporation, to name a few. In addition, the association has long had a survey alternative model based on quality indicators that will be of significance.

One of the other things I would like to point out, though, is that in none of these discussions so far have we talked about the physician's role in any of this. The physician should be vitally involved in these programs and in the kinds of parameters we put in place that we raise the bar of quality of care using their input as well.

One of the things I would like to suggest is that the certified medical director level be required of medical directors in our facilities, that they have gone through the process of gaining that additional body of knowledge to help with quality issues in the facilities. This would be a basic thing to do.

One of the other interesting things about the study that was done is we did a study in one of the facilities that was involved in the GAO report and found that physician involvement had a direct impact on quality of care when measured by return to hospital. If physicians were there on a frequent basis and involved in the patient care, the reduction in return to hospital was from 23 percent to 11 percent. Therefore, physician involvement truly can be of value in this process.

I would like to cut short now and just leave it open to questions. Thank you very much.

The CHAIRMAN. Thank you very much.

[The prepared statement of Dr. Stone follows:]

STATEMENT OF DENNIS STONE M.D., MBA, CMD
Representing the California Association of Health Facilities

U.S. Senate, Special Committee on Aging
"Betrayal; The Quality of Care in California Nursing Homes"
Hearing
July 28,1998

Mr. Chairman and members, I am Dr. Dennis Stone, speaking on behalf of the California Association of Health Facilities which is a non-profit, professional organization dedicated to improving health care. CAHF's membership is comprised of more than 1,500 licensed long term care facilities serving a wide spectrum of health needs in settings which include: skilled nursing, intermediate, subacute, mental health, rehabilitation and residential; along with providers of services for persons with developmental disabilities. Nearly 100,000 trained medical, professional and support service staff care for 200,000 Californians residing in these member facilities each year. CAHF is affiliated with the Quality Care Health Foundation, the Council of Long Term Care Nurses of California and the American Health Care Association.

I am an MD, graduating from University of Oregon Medical School. In addition, I have served as a medical director in nursing homes and am certified by American Medical Directors Association. I have been the corporate medical director for Regency Health Services and Beverly Health and Rehabilitation, Inc. I am the vice president of American Medical Directors Association and have served as president of the California Association of Medical Directors. I have an MBA in Health Services Management and a certification in gerontology.

I will make some comments and then would be happy to respond to your questions. Although I have heard descriptions of the content and recommendations of the GAO's report, I am at a disadvantage not having had a copy of the final report to review, but my comments will address quality of care issues in California nursing homes.

Health care providers in nursing homes do not condone poor quality of care. I am shocked and dismayed that once again the issue of quality of care in California nursing homes is being addressed through innuendo, poor investigative and research processes and utilization of data from a survey and enforcement system that is misleading, unfair and inconsistently applied.

There is no question that care issues do occur, but the real question is, could unfortunate incidents have been avoided by the implementation of available care or, due to other factors, were allegations of poor care unavoidable outcomes. It appears, once again, the assumption has been made that all negative patient outcomes such as decubitus ulcers, malnutrition, incontinence and dehydration are caused by the lack of or inadequate implementation of care interventions and that nursing home providers of care are to blame.

This assumption ignores current scientific research which demonstrates that care of the aged is an extremely complex area further complicated by the "normal aging" process, the rights of the patient to forego treatment at the end of life stage, and lack of established "gold standards" for care interventions and defined outcomes for such interventions. All of the care needs of the older adult patient can not be readily

isolated because of the synergistic effect of the physiological, social, economic and psychological changes concomitant with aging. For example, we see survey deficiency statements which equate optimum caloric intake with guaranteed optimal nutrient intake and desired patient outcomes (e.g., lack of skin breakdown). It is not possible to attribute malnutrition or even weight loss to any single cause because they are due to a combination of factors. Yet the data, which shows that some nursing homes do not comply with Medicare/Medicaid nutrition and hydration requirements, are often predicated on a single causal relationship. The same holds true for other areas of care such as incontinence. Urge, overflow, stress and functional incontinence are lumped together and no differentiation is made as to whether or not appropriate interventions are feasible. For example, a demented patient, who is incapable of following instructions, is unable to implement certain care modalities. It is not a simplistic cause and effect relationship as the "enforcement" data bases would lead the less informed to believe.

Geriatric medicine and care of the geriatric patient is still in its infancy and far from the exact science that health care in younger adult patients is reaching. Geriatric patients are less like each other and much more individualism of care is needed. It is one of the great challenges for people who practice in this area. Just as the mislabeling of normal aging as a disease may be the result of lack of knowledge of physiological changes brought about by aging, so too there is a great risk in sensationalizing health conditions of the aged patient as caused by lack of and/or poor care interventions. There is no one simple "cookbook " approach to treat patients who, at 65+, have the identified effects of aging i.e., (decreased bone density, decreased fat and muscle mass); multiple chronic diseases for which medications are

being given; and impaired mental and physical capabilities. For example, fifty percent of patients in California nursing homes have dementia and/or mental illness and forty to fifty percent need some assistance with activities of daily living. Many have exercised their rights to forgo end of life treatment interventions. Forty-six percent of the patients in California nursing homes have executed an advance directive.

There is no question that malnutrition in the aged is a tremendous problem. Studies have estimated occurrences of malnutrition in fifty percent of the population in hospitals and forty percent of nursing home patients. Other studies have shown that fifty-four percent of patients admitted to nursing homes are malnourished. Most nursing home admissions come from acute hospitals

Does the malnutrition occur because the patient has refused nutrition? What about the patient's other pathology such as depression and/or normal aging occurrences such as decline in ability to taste and decrease in sense of smell which has lessened the drive to obtain nutrition? Have the patients disease processes decreased or obliterated his or her ability to digest, assimilate and utilize nutrients? Or, is it because patient food preferences, eating abilities and pathology, that is responsive to treatment, is not being addressed through the provision of care? The survey data from California would have lead you to believe that it is a question of poor quality of care. We do not believe that this is a fair measurement of quality of care. Quality of care issues need to be fairly identified and appropriately addressed. I have attached a recent journal article to this testimony which addresses some of these issues.

Funding

Patient acuity levels continue to rise in our state, but the reimbursement for care has essentially remained stagnant. California's average Medicaid reimbursement ranks 34th among the states, far below the U.S. average. Efforts to continue to improve care at reasonable costs have been difficult when sixty-five percent of nursing home patient's care is paid for through the Medicaid program. Congressional actions last year to eliminate the Boren Amendment only makes this problem worse. Quality care is not free -- it requires reasonable funding levels.

The concept of "Best Practices", long ago implemented by California providers, and quality improvement need much more attention than is currently being paid to them. The effectiveness of these programs needs to be measured. Currently, patient outcome data measurement is predicated on negatives-incontinence, decubitus ulcer, malnutrition and dehydration. We need to focus on positive measurements, lack of incontinence, skin integrity, maintenance of reasonable body weights and hydration levels. We need to ask what the care interventions are that work.

The Association has always been supportive of research efforts. Many of its members have participated in much needed research done through the University of California system, the Andrus Center and the Rand Corporation to name a few. In addition, the Association has advocated for a survey alternative model based on quality improvement and measurement of positive outcomes. We would like to see this model implemented on a pilot basis. Unfortunately, the current leadership at HCFA is not willing to even consider this innovative approach.

Regulatory Revision

Adding to the difficulty of defining innovative approaches to care has been the regulatory system which at times restrains the implementation of solutions for care issues. For example, today, a dietary aide can not feed a patient in a nursing home unless the aide has been through the CNA certification program due to HCFA's interpretation of regulatory requirements. In California, our CNA training programs have double the nationally required number of hours (150 hours). A more cost effective solution would be to have specialized training programs i.e., put a dietary aide through a special nutrition and feeding program. In an era where cross-training and the team concept have been ingrained in the educational and business world, health care providers are prohibited from utilizing available staff to their maximum level. The interdisciplinary team concept contained in the OBRA regulations is limited. Additional state licensure requirements which, for example, state that all three meals must be given within 14 hours add to this burden. This is hardly a requirement that recognizes the individuality of the patient. Health care regulations and policy need to be revised to allow for innovative approaches to care.

Data

The limitations of information tools used to collect data must be recognized. The survey and certification system, based solely on the individual surveyor judgment, has been shown in studies to have serious flaws. The study done by Abt Associates to evaluate the survey process found that, in California, fifty percent of the surveys did not address patient outcomes in the deficiency statement showing noncompliance with regulatory requirements.

The Minimum Data Set (MDS) tool which is now being used to collect patient specific information has flaws. Valuable information is missing from this tool and has made it necessary for providers to develop other patient assessment tools to collect information necessary to the care of the patient. Yet this is the data collection tool which will drive reimbursement, focused enforcement and research. We must remember that it collects **minimum** data. Data, such as this, which contains indicators such as pressure sores, incontinence and dehydration should only be used as indicative of a possible care issue and not as a measurement of the quality of care. The misuse of data to define quality of care is ethically and morally wrong and, in cases such as this, is a grave injustice to the committed personnel who care for the nation's aged in nursing homes.

I thank you for your time and would be happy to answer any questions.

Special Article

Nutritional Deficiencies in Long-Term Care: Part I

Detection and Diagnosis

By John E. Morley, MB, BCh, David R. Thomas, MD, and Hossam Kamel, MD

Abstract

Nutrition is a key component of nursing home resident care. This article highlights the importance of anorexia and weight loss in the nursing home and discusses the problems associated with diagnosing protein-energy malnutrition. Weight loss and albumin are the key indications of malnutrition in the nursing home environment, and the MiniNutritional Assessment appears to be the most appropriate screening instrument for this condition.

Introduction

Weight loss is a key indicator of poor performance in the nursing home. The majority of persons with weight loss in a nursing home either have protein-energy malnutrition or dehydration. The appropriate recognition and management of protein-energy malnutrition in nursing homes remains one of the major challenges for all health professionals. The diagnosis of vitamin B_{12} deficiency can explain alterations in mental status and hematocrit in nursing home residents. In some residents, calcium and vitamin D replacement reduces the risk of hip fracture. Zinc deficiency can be associated with poor healing of pressure ulcers.

In this series of three articles, we will discuss the common nutritional problems that occur in nursing home residents and the approach to their diagnosis (Part I), the management of nutritional problems in the nursing home (Part II), and the requirements of state and national regulations on approaches to nutritional problems in nursing homes (Part III).

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Physiologic Anorexia of Aging

It is now clearly established that there is a decline in food intake throughout the life span.[1] This decline occurs despite the fact that weight increases in middle age, suggesting that much of this weight gain is due to the decline in resting metabolic rate and physical activity that occurs with aging. In the old-old (over age 85), there is a tendency to lose weight and adipose tissue mass.[2] These physiologic changes mean that older persons are particularly at risk for developing severe anorexia and weight loss when they contract diseases.

Changes in the hedonic qualities of food occur universally with aging. These changes are due particularly to declines in olfaction[3] and taste[4] that occur with aging. Whereas the ability to smell declines in all individuals, the changes in taste are more variable. Individuals who have smoked are more likely to experience declines in taste. The major change in taste is the increase in the threshold at which one can recognize a taste. The primary factors involved in altering taste with aging are the effects of drugs and diseases on taste rather than the physiologic changes of aging (Table I). Schiffman et al[5] demonstrated that nursing home residents preferred foods that had flavor enhancers added, which

produced a tendency for them to ingest greater quantities of food.

These changes in taste and smell are extremely important in nursing home residents. Residents commonly complain about the quality of food in nursing homes. Much of this dissatisfaction is due to the physiologic alterations in taste and smell that make food appear less "tasty" as humans age. Alterations in the ability to appreciate the taste of food (most of which are due to decreased olfaction) mean that in the nursing home, food presentation and food choice play a more important role than the actual taste of the food. In Finnish nursing homes, residents are involved in the preparation of their own food. Such an approach is further likely to decrease the complaints about food quality (personal communication, 1997).

TABLE I

MAJOR PATHOLOGIC AND IATROGENIC CAUSES OF A DECLINE IN TASTE OR SMELL

- Central Nervous System Disorders
  - Dementia
  - Parkinson's disease
  - Head trauma
- Metabolic Disorders
  - Addison's disease (adrenocortical insufficiency)
  - Diabetes mellitus
  - Hypothyroidism
- Systemic Disorders
  - Cirrhosis of the liver
  - Zinc deficiency
  - Chronic renal failure
  - Cancer
- Psychological Disorders
  - Depression
- Local Conditions
  - Radiation
  - Sinusitis
  - Sjögren's syndrome
  - Rhinitis
- Medications
  - Cholesterol-lowering drugs
  - Antihistamines
  - Antibiotics
  - Antiasthmatics
  - Antihypertensives
  - Diuretics

Many older persons are unable to eat the same quantity of food at a single meal as they ate when they were younger. This early satiation appears to be secondary to a diminished ability of the fundus of the stomach to display appropriate adaptive relaxation at the presence of food.[6] This results in food passing more rapidly from the fundus to the antrum of the stomach. Food in the antrum causes increased antral stretch, which appears to be the major signal for fullness.[7]

With aging, there is an increase in the levels of cholecystokinin (CCK), a gastrointestinal hormone involved in producing physiologic satiation.[8] This increase in CCK levels is more marked in malnourished older individuals. In addition, animal studies have suggested that CCK may be more effective at producing satiation in older compared to younger rodents.[6]

Previous human studies have suggested that older persons are less likely than young individuals to be satiated when food is delivered directly into the duodenum.[9] This finding can be important in the management of malnutrition because it suggests that the liquid caloric supplements that pass rapidly into the duodenum may be better for caloric supplementation than caloric-fortified solid foods in this population. Preliminary data suggest that having healthy older persons ingest a liquid supplement 60 minutes before a meal does not alter the number of calories eaten at the subsequent meal (Wilson MM and Morley JE, unpublished data, 1997). In addition, liquid supplements where the calories are supplied by glucose rather than fat are less likely to interfere with subsequent satiation because fat, but not glucose, slows gastric emptying.[10]

Leptin is a hormone produced by fat cells. It

decreases food intake and increases metabolism. Leptin levels decline with age in women but not in men. The failure of leptin to decline with age in men is most probably due to the decline in testosterone levels with aging.[11] Whether or not the increased leptin levels in males play a role in the greater degree of physiologic anorexia seen in older males compared to females has not yet been elucidated. In addition to leptin, circulating cytokines, such as tumor necrosis factor alpha (cachectin), also reduce food intake, produce muscle wasting, and inhibit albumin synthesis.[12]

Within the central nervous system, numerous neurotransmitters regulate food intake. At present, no human studies have been undertaken to determine whether alterations in these neurotransmitters caused by aging play a role in anorexia associated with aging. Animal studies have suggested that alterations in the endogenous opioid feeding drive may result in a decline in fat intake with aging.[13] A single human study found that older persons lose their endogenous opioid drive to drink and that this loss may play a role in the hypodipsia of aging.[14]

Overall, the accumulated data suggest that aging is associated with declines in the drive to eat and drink. Numerous factors appear to be involved in producing these physiologic age-related changes. In part, they occur to offset the decrease in resting metabolic rate and physical activity that occur as people age. Whatever the physiologic mechanisms responsible for these changes, they place older people at major risk for developing malnutrition and dehydration when they are in the nursing home.

Prevalence of Malnutrition

The prevalence of protein-energy malnutrition (PEM) varies with the population observed and the definition of malnutrition. In the United States, health care professionals estimate that 40% of nursing home patients and 50% of hospitalized patients over the age of 65 are malnourished. Forty-four percent of home health patients are estimated to be malnourished.[15] These subjective estimates are close to prevalence results reported in clinical trials. Among patients newly admitted to a long-term care setting, a point prevalence of 54% malnutrition was observed.[16] In a Swedish study, 29% of newly admitted patients at a long-term care geriatric hospital were malnourished on admission.[17] The range for PEM in nursing home residents varies from 23% to 85%.[18,19] By comparison, the prevalence of PEM ranges from 32% to 50% in acutely hospitalized patients.[20,21] Other reports confirm that malnutrition is a major problem among residents in long-term care facilities.[22-24] The high prevalence of malnutrition in nursing homes may in part reflect transfer of malnourished patients from acute care hospitals to long-term care facilities following an acute illness.

The prevalence varies also with the criteria used to define malnutrition. The diagnosis of PEM in elderly populations is difficult. Anthropometric and biochemical measurements are usually performed to define type and severity of malnutrition, but there is no "gold standard" for diagnosis. Body weight, weight/height (body mass index), triceps skinfold thickness, arm circumference, arm muscle area, and arm fat area are the most commonly used anthropometric variables.[16] A broad panel of biochemical variables has been advocated to provide useful nutritional information. Serum albumin concentration is the single most commonly recommended parameter,[25] although lymphocyte count and concentrations of hemoglobin, prealbumin, transferrin, and retinol binding protein are also recommended. No single biologic parameter is satisfactory as a predictor of residents at risk for PEM.[26] The discriminant cutoffs for each variable continue to be disputed.[27-29]

Little is known about whether PEM persists or improves after admission to a long-term care facility. Studies in an academic nursing home have shown that 60% of residents experienced a net weight loss following admission.[18] Dietary interventions and nutritional supplements may improve malnutrition in long-term care settings. Weight gain occurred in 50% of malnourished patients, compared to weight gain in 58% of nonmalnourished patients (odds

ratio, 0.70; 95% confidence; limits, 0.14, 3.46). Improvement in PEM occurred in 63% of the initially malnourished residents. However, 37% of residents remained malnourished.[16]

The number of malnourished patients in hospital settings may be decreasing over time as nutritional awareness increases. Using the same assessment scale at one institution, 38% of hospitalized patients were found to be at risk for malnutrition in 1988, compared to 48% of patients in 1976.[30] Similar data for patients in long-term care are not available.

Diagnosis of Malnutrition

As alluded to in the previous section, making the diagnosis of malnutrition in an older person is often extremely difficult. All the so-called "gold stan

Table II

Clinical Signs of Nutritional Deficiencies

Protein-Calorie Malnutrition	B-Complex Vitamins	Vitamin C	Zinc
Weight loss	Ophthalmoplegia (thiamine)	Calf tenderness and swelling	Dysgeusia Acrodermatitis Enterohepatica
Muscle wasting			
-temporalis muscle	Decreased position and vibration sense	Petechiae Purpura	Poor wound healing
-between thumb and index finger	Ataxia (B_{12})	Arthralgias	Night blindness
-calf	Cheilosis		
Subcutaneous loss of fat	(B_6, niacin, riboflavin)	Wound breakdown	
Sparse, dull hair	Glossitis		
Orthostasis	(Niacin, folate, B_{12})		
Edema	Dermatitis		
Poor wound healing	Pellagra		
Decreased food intake	High output failure (thiamine)		
Hepatomegaly			
Pallor (anemia)	Delirium (B_{12}, folate, thiamine)		
Cognitive impairment			
Parotidomegaly	Angular fissures periorally		
Weak cough	(B complex)		
Decreased grip strength	Macrocytic anemia (B_{12}, folate)		

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dards" have ultimately had an element of "fool's gold" mixed in. Thus, the eye of the astute, nutritionally aware physician remains perhaps the best means of recognizing impaired nutritional assessment (Table II).

Jeejeebhoy et al[31-33] have attempted to quantify the factors that a nutritionist uses to recognize malnutrition. This attempt has led to the development of the subjective global assessment (SGA). Persons with severe nutritional deficits (grade C) are those with changes in dietary intake and body mass (greater than 10% weight change over the last 6 months) and poor functional status. Grade B is scored when there is evidence of food restriction and functional changes but minimal weight change. Grade A is minimal or no changes in food intake, improving body weight, and minimal change in function. This method has a reasonable interobserver agreement rate of 81% to 91%. Grade C is associated with a 7-fold increase in the likelihood of complications in patients undergoing gastrointestinal surgery. The SGA appeared to be better than any single objective nutritional parameter in assessing the likelihood that a person will develop nutrition-related complications. However, the SGA has not been validated in the nursing home environment.

Food intake represents a potentially important tool in monitoring persons at risk for malnutrition in the nursing home. Unfortunately, recent studies have suggested that the recording of the amount of food eaten in nursing homes is highly inaccurate.[34] Although counting calories by weighing all food before and after the meal would be more accurate, it is rarely feasible in the long-term care setting. Nurse's aides can be trained to be more accurate in estimating the amount of food ingested, but doing so requires a substantial time investment.

Weight loss remains one of the best indications of nutritional risk in nursing homes. All nursing homes should have a flow chart giving monthly weights in each resident's record. Because scales in nursing homes often malfunction, it is helpful if the persons responsible for recording residents' weights actually weigh themselves each day on each scale. Residents need to be weighed at the same time of the day each month, dressed in a minimal amount of clothing and without shoes. Obviously, both congestive heart failure and dehydration can alter weights. Height needs to be obtained on admission and reobtained yearly to allow identification of height loss due to osteoporosis.

A variety of other anthropometric tools are available to measure nutritional status. Overall, these tools have not been proven very useful in the nursing home. Of the skinfold thicknesses, the triceps measurement is most useful in females, and the subscapular measurement is more accurate in males. Mid-arm circumference or mid-arm muscle circumference can be a useful measurement in residents with major alterations in water metabolism. In these residents, mid-arm circumference needs to be recorded alongside the resident's weight. The former will be a more accurate indicator of protein loss from muscle.

Whereas measurements of circulating proteins can be useful to judge the degree of protein malnutrition, multiple nonnutritional factors can interfere with their levels. Albumin has a long half-life (21 days), making it less useful as a measurement of acute nutritional status. Two factors often associated with illness can, however, produce acute changes in albumin levels. Recumbency is associated with an increased intravascular volume, and the dilutional effect can lower serum albumin levels by as much as 0.5 mg/dl.[35] Cytokine release not only inhibits albumin synthesis but also causes extravasation of albumin from the intravascular to the extravascular space.[36] These 2 factors explain the rapid decline in albumin levels that are often experienced when older patients are admitted to the hospital. Nevertheless, albumin levels of 3.2 g/dl or less remain an excellent predictor of morbidity and mortality in older persons.[37]

Proteins with a shorter half-life, such as prealbumin (2 days) and retinol binding protein (RBP; 2 hours), are occasionally useful to determine response to nutritional supplementation. Prealbumin levels are subject to all the vagaries experi-

TABLE III

COMPARISON BETWEEN MARASMIC AND KWASHIORKOR TYPES OF PROTEIN-ENERGY MALNUTRITION*

	Marasmus	Kwashiorkor
Pathophysiology	Decreased calories	Decreased protein intake Cytokine release due to acute and/or chronic stress
Energy needs	Decreased	Increased
Clinical	Weight loss Loss of subcutaneous fat Decreased mid-arm muscle circumference Less than 90% of standard weight for height Ketones in urine	Appear well-nourished or obese Edema Hair loss No ketones
Biochemical	Albumin > 3.2 g/dl	Albumin < 3.2 g/dl Anergy Lymphocytes < 1200/mm^3 Decreased CD_4 cells
Response to illness	Albumin may drop precipitously Responds adequately to infection Mortality low	Immunocompromised High rate of infections Poor wound healing Mortality high
Metabolism	Decreased proteolysis Increased glycogenolysis and lipolysis Decreased insulin	Rapid proteolysis Increased glycogenolysis and lipolysis Insulin resistance
Respiratory quotient	0.75 (lipids)	0.85 (mixed fuel source)
Total body water	Decreased	Increased
Response to feeding	Anabolism	Catabolism difficult to reverse

*Many nursing home residents have a mixed presentation.

enced by albumin. In addition, levels are increased with decreased creatinine clearance because the kidney is the major metabolic site. RBP is a glycoprotein that has its levels altered by vitamin A, zinc, or carbohydrate in the diet and by renal disease.

Acute phase reactants, such as fibronectin, have also been used to identify malnourished patients, but they are clearly more related to disease than to nutritional status. Recently, soluble interleukin-2 receptors have been shown to be a good correlate of

TABLE IV

MINI-NUTRITIONAL ASSESSMENT

Last Name: _____ First Name: _____ M.I. ____ Sex: ____ Date: _____

Age: _____ Weight (kg): _____ Height (cm): _____ Knee Height (cm): _____

Complete the form by writing the numbers in the boxes. Add the numbers in the boxes and compare the total assessment to the Malnutrition Indicator Score.

Anthropometric Assessment	Points
1. Body Mass Index (BMI) (weight in kg)/(height in m)² a. BMI< 19 = 0 points b. BMI 19 to < 21 = 1 point c. BMI 21 to < 23 = 2 points d. BMI >23 = 3 points	
2. Mid-arm circumference (MAC) in cm a. MAC < 21 = 0.0 points b. MAC 21 ≤ 22 = 0.5 points c. MAC > 22 = 1.0 points	
3. Calf circumference (CC) in cm a. CC < 31 = 0 points b. CC > 31 = 1 point	
4. Weight loss during last 3 months a. weight loss greater than 3 kg (6.6 lb) = 0 points b. does not know = 1 point c. weight loss between 1 and 3 kg = 2 points d. no weight loss = 3 points	
General Assessment	
5. Lives independently (not in a nursing home or hospital) a. no = 0 points b. yes = 1 point	
6. Takes more than 3 prescription drugs per day a. yes = 0 points b. no = 1 point	
7. Has suffered psychological stress or acute disease in the past 3 months a. yes = 0 points b. no = 1 point	
8. Mobility a. bed or chair bound = 0 points b. able to get out of bed/chair but does not go out = 1 point c. goes out = 2 points	
9. Neuropsychological problems a. severe dementia or depression = 0 points b. mild dementia = 1 point c. no psychological problems = 2 points	
10. Pressure sores or skin ulcers a. yes = 0 points b. no = 1 point	
Dietary Assessment	
11. How many full meals does the patient eat daily? a. 1 meal = 0 points a. 2 meals = 1 point a. 3 meals = 2 points	

	Points
12. Selected consumption markers for protein intake • At least one serving of dairy products (milk, cheese, yogurt) per day Yes ☐ No ☐ • Two or more servings of legumes or eggs per week Yes ☐ No ☐ • Meat, fish, or poultry every day Yes ☐ No ☐ a. 0 or 1 yes = 0.0 points b. 2 yes = 0.5 points c. 3 yes = 1.0 points	
13. Consumes two or more servings of fruits or vegetables per day a. no = 0 points b. yes = 1 point	
14. Has food intake declined over the past 3 months due to loss of appetite, digestive problems, chewing or swallowing difficulties? a. severe loss of appetite = 0 points b. moderate loss of appetite = 1 point c. no loss of appetite = 2 points	
15. How much fluid (water, juice, coffee, tea, milk . . .) is consumed per day? (1 cup = 8 oz.) a. less than 3 cups = 0.0 points b. 3 to 5 cups = 0.5 points c. more than 5 cups = 1.0 points	
16. Mode of feeding a. unable to eat without assistance = 0 points b. self-fed with some difficulty = 1 point c. self-fed without any problem = 2 points	
Self-Assessment	
17. Do they view themselves as having nutritional problems? a. major malnutrition = 0 points b. do not know or moderate malnutrition = 1 point c. no nutritional problem = 2 points	
18. In comparison with other people of the same age, how do they consider their health status? a. not as good = 0.0 points b. do not know = 0.5 points c. as good = 1.0 points d. better = 2.0 points	
Assessment Total (max. 30 points)	

Malnutrition Indicator Score

☐ ≥ 24 points = well-nourished ☐ 17 to 23.5 points = at risk of malnutrition ☐ < 17 points = malnourished

Table V

SCALE: An Instrument for the Detection of Malnutrition in Nursing Homes

Sadness (Geriatric Depression Scale)
Cholesterol less than 160 mg/dl
Albumin less than 3.5 mg/dl
Loss of 5% of body weight
Eating problems (physical or cognitive)

outcomes in malnourished hospitalized patients.[38] They appear to be a good marker of catabolic states.

Low total cholesterol levels are also a measure of nutritional status. However, like albumin, the cholesterol level is altered by cytokines. Levels of cholesterol below 156 mg/dl are highly predictive of poor outcomes in nursing homes.[39]

Leptin levels are an excellent marker of total body fat.[40] As such, they have major potential as a nutritional marker. Anemia is often due to protein-energy malnutrition, and successful nutritional rehabilitation can reverse much of the anemia of chronic disease. Lymphocytopenia and, in particular, low CD_4 cell levels are good indicators of malnutrition.[41] Anergy to delayed cutaneous hypersensitivity testing for common antigens, such as *Candida*, is seen in malnourished persons. It can be reversed with nutritional support[42] and is related to increased septicemia and mortality.[43]

Malnutrition results in atrophy of muscle fibers and 2-band degeneration, which presents physiologically as the inability to maintain tetonic contractions, delayed relaxation rate, and reduced force generation. Clinically, it can be examined by measuring grip strength with a dynamometer. A decline in respiratory muscle function can be suspected in persons who have a weak cough.

In the nursing home, measurements of body composition can be obtained utilizing bioelectrical impedance with appropriate formulae.[44] However, other factors, such as dehydration and altered height secondary to osteoporosis, make the reliability of this technique highly suspect in the nursing home. The use of other techniques for measuring body composition are either not suitable for the majority of nursing home residents or are predominantly used for research purposes (eg, stable isotopes or underwater weighing).

Two types of protein-energy malnutrition exist—namely, marasmus and kwashiorkor (Table III). Marasmus is characterized by weight loss, whereas kwashiorkor shows a specific rapid decline in serum albumin levels. Marasmus is predominately due to poor food intake, whereas kwashiorkor is usually precipitated by cytokine release associated with an acute stressor.

The Nutritional Screening Index was developed to identify persons at risk for malnutrition.[45] It has poor sensitivity and specificity.[46] It should not be used in the nursing home environment.

The MiniNutritional Assessment (MNA) is the best validated of the nutritional screening tools,[47,48] and it is appropriate for use in nursing homes. Its major advantage is that it does not use laboratory tests, and so it is highly cost-effective. In the authors' experience, it is an excellent tool for screening persons on admission to nursing homes. The MNA form is shown in Table IV.

SCALE (Table V) was developed by the authors for identification of malnutrition in the outpatient setting.[49] SCALE has been cross-validated with the MNA (Miller DK and Morley JE, unpublished data, 1997). This assessment tool is appropriate for use in the nursing home, although the shopping/food preparation criteria are dropped. SCALE appears to be a useful method for detecting early malnutrition risk in nursing homes.

It should be clear that the assessment of nutritional deficiency is extremely difficult. No single measurement is ideal. Clinical judgment remains the "gold standard." The second part of this series will discuss the causes of nutritional deficiencies and their appropriate management.

References

1. Anonymous. Daily dietary fat and total food energy intakes: Third National Health and Nutrition Examination Survey, phase IIa 1988-1991. *MMWR Morb Mortal Wkly Rep* 1994;43:116-125.
2. Steen B. Body composition and aging. *Nutrition Reviews* 1988;46:45-51.
3. Doty RL, Shaman P, Applebaum SL, et al. Smell identification ability: Changes with age. *Science* 1984;226:1441-1443.
4. Schiffman S. Food recognition by the elderly. *J Gerontol* 1977;32:586-592.
5. Schiffman SS, Warwick ZS. Effect of flavor enhancement of foods for the elderly on nutritional status: Food intake, biochemical indices, and anthropometric measures. *Physiol Behav* 1993;53:395-402.
6. Morley JE. Anorexia of aging: Physiologic and pathologic. *Am J Clin Nutr* 1997;66:760-773.
7. Jones KL, Doran SM, Hveem K, et al. Relation between postprandial satiation and antral area in normal subjects. *Am J Clin Nutr* 1997;66:127-132.
8. Bertelemy P, Bouisson M, Vellas B, et al. Postprandial cholecystokinin secretion in elderly with protein-energy under-nutrition. *J Am Geriatr Soc* 1992;40:365-369.
9. Cook CG, Andrews JM, Jones KL, et al. Effects of small intestinal nutrient infusion on appetite and pyloric motility are modified by age. *Am J Physiol* 1997;273:R755-R761.
10. Shafer RB, Levine AS, Marlette JM, Morley JE. Do calories, osmolality, or calcium determine gastric emptying? *Am J Physiol* 1985;248:R479-R483.
11. Sih R, Morley JE, Kaiser FE, et al. Testosterone replacement in older hypogonadal men: A 12-month randomized controlled trial. *J Clin Endocrinol Metab* 1997;82:1661-1667.
12. Maguid MM, Yang ZJ, Gleason JR. The gut-brain brain-gut axis in anorexia: Toward an understanding of food intake regulation. *Nutrition* 1996; 12:557-562.
13. Gosnell BA, Levine AS, Morley JE. The effects of aging on opioid modulation of feeding in rats. *Life Sci* 1983;32:2793-2799.
14. Silver AJ, Morley JE. Role of the opioid system in the hypodipsia associated with aging. *J Am Geriatr Soc* 1992;40:556-560.
15. Peter D. Hart Research Associates Inc. Nutrition Screening Initiative: Telephone survey of 750 doctors, nurses, and healthcare administrators. April 1-8, 1993.
16. Thomas DR, Verdery RB, Gardner L, et al. A prospective study of outcome from protein-energy malnutrition in nursing home residents. *J Parenter Enteral Nutr* 1991;15:400-404.
17. Larsson J, Unosson M, Ek A-C, et al. Effect of dietary supplement on nutritional status and clinical outcome in 501 geriatric patients: A randomized study. *Clin Nutr* 1990;9:179-184.
18. Silver AJ, Morley JE, Strome LS, et al. Nutritional status in an academic nursing home. *J Am Geriatr Soc* 1988;36:487-491.
19. Shaver HJ, Loper JA, Lutes RA. Nutritional status of nursing home patients. *J Parenter Enteral Nutr* 1980;4:367-370.
20. Willard MD, Glasdorf RB, Price RA. Protein-calorie malnutrition in a community hospital. *JAMA* 1980;244:1720-1722.
21. Bistrian BR, Blackburn GL, Vitale J, et al. Prevalence of malnutrition in general medical patients. *JAMA* 1976;235:1567-1570.
22. Lipschitz DA. Protein calorie malnutrition in the hospitalized elderly. *Primary Care* 1982;9:531-543.
23. Pinchcofsky-Devin GD, Kaminski MV. Incidence of protein calorie malnutrition in the nursing home population. *J Am Coll Nutr* 1987;6:109-112.
24. Redman D, Feller AG. Protein-calorie undernutrition in the nursing home. *J Am Geriatr Soc* 1989;37:173-183.
25. Dionigi R, Dominioni L, Jemos V, et al. Diagnosing malnutrition. *Gut* 1986;27:5-8.
26. Neitherout WD, Smith ADS, McAllister J, LaFeda G. Nutritional survey of patients in a general surgical ward: Is there an effective predictor of malnutrition? *J Clin Pathol* 1987;40:803- 807.
27. Kergoat MJ, Leclerc BS, Perd'Clerc C, Imbach A. Discriminant biochemical markers for evaluating the nutritional status of elderly patients in long-term care. *Am J Clin Nutr* 1987;46:849-861.
28. Morgan DB, Newton HM, Schoenh CJ, et al. Abnormal indices of nutrition in the elderly: A study of different clinical groups. *Age Ageing* 1986;15: 65-76.
29. Bastow MD. Anthropometrics revisited. *Proc Nutr Soc* 1982;41:381-388.
30. Coats KG, Morgan SL, Bartolucci AA, Weinsier RL. Hospital-associated malnutrition: A reevaluation 12 years later. *J Am Diet Assoc* 1993;93:27-33
31. Jeejeebhoy KN, Detsky AS, Baker JP. Assessment of nutritional status. *J Parenter Enteral Nutr* 1990;14:193S-196S.
32. Detsky AS, Baker JP, O'Rourke K, et al. Predicting nutrition-associated complications for patients undergoing gastrointestinal surgery. *J Parenter Enteral Nutr* 1987;11:440-446.
33. Detsky AS, Smalley PS, Chang J. Is this patient malnourished? *JAMA* 1994;271:54-58.
34. Kayser-Jones J, Schell E. The effect of staffing on the quality of care at mealtime. *Nursing Outlook* 1997;45:64-72.
35. Dixon M, Paterson CR. Posture and the composition of plasma. *Clin Chem* 1978;24:824-826.
36. Ling PR, Schwartz JH, Bistrian BR. Mechanisms of host wasting induced by administration of cytokines in rats. *Am J Physiol* 1997;272:E333-E339.
37. Miller DK, Morley JE. Nutritional epidemiology. *Ann Rev Gerontol Geriatr* 1995;15:20-53.
38. Rosenthal AJ, McMurrey CT, Sanders KM, et al. The soluble interleukin-2 receptor predicts mortality in older hospitalized men. *J Am Geriatr Soc* 1997;45:1362-1364.
39. Redman D, Mattson DE, Nagrej HS, et al. Prognostic significance of serum cholesterol in nursing home men. *J Parenter Enteral Nutr* 1988;12:155-158.
40. Perry HM 3rd, Morley JE, Horowitz M, et al. Body composition and age in African-American and Caucasian women: Relationship to plasma leptin levels. *Metabolism* 1997;46:1399-1405.
41. Kaiser FE, Morley JE. Idiopathic CD4+ lymphopenia in older persons. *J Am Geriatr Soc* 1994;42:1291-1294.
42. Bistrian BR, Sherman M, Blackburn GL. Cellular immunity in adult marasmus. *Arch Intern Med* 1977;137:1408-1411.
43. Meakins JL, Pietsch JB, Bubenick O. Delayed hypersensitivity: Indicator of acquired failure of host defenses in sepsis and trauma. *Ann Surg* 1977; 186:241-250.
44. Silver AJ, Guillen CP, Kahl MJ, Morley JE. Effect of aging on body fat. *J Am Geriatr Soc* 1993;41:211-213.
45. White JV, Dwyer JT, Posner BM, et al. Nutrition screening initiative: Development and implementation of the public awareness checklist and screening tools. *J Am Diet Assoc* 1992;92:163-167.
46. Posner BM, Jette AM, Smith KW, Miller DR. Nutrition and health risks in the elderly: The Nutrition Screening Initiative. *Am J Public Health* 1993; 83:972-978.
47. Guigoz Y, Vellas B, Garry PJ. Assessing the nutritional status of the elderly: The Mini Nutritional Assessment as part of the geriatric evaluation. *Nutr Rev* 1996;54:S59-S65.
48. Lauque S, Paissant C, Boerdille S, et al. Nutritional evaluation of the elderly patient: A much used test: The mini-nutritional assessment (MNA). *Soins Geron ologie* 1996;2:25-27.
49. Morley JE. Why do physicians fail to recognize and treat malnutrition in older persons? *J Am Geriatr Soc* 1991;39:1139-11

The CHAIRMAN. Dr. Willging.

STATEMENT OF PAUL R. WILLGING, EXECUTIVE VICE PRESIDENT, AMERICAN HEALTH CARE ASSOCIATION

Dr. WILLGING. Thank you, Mr. Chairman. I appreciate the opportunity to appear before you and the committee today. I would like to begin by commending you and commending your colleagues on the committee for your longstanding, sincere and committed effort toward the well-being of America's seniors. It is noted, and it is appreciated.

I am here today representing the vast, vast majority of America's nursing facilities. I am here representing those who day in and day out, under very difficult circumstances, are providing exemplary care, the kind of care America's seniors have every right to expect. I am here also, however, Mr. Chairman, because I am worried about that small minority. I am worried about the 5 percent.

I am worried about those who make it difficult for the vast majority to do their jobs. I am worried about the small minority because, quite frankly, we cannot continue to tolerate them. We cannot continue to see them providing the kind of care that has been documented over the past day or two. I am concerned, and have been concerned, as you are well aware, with the tendency on the part of the General Accounting Office to perhaps extrapolate the numbers larger than the facts would warrant. Indeed, as you may recall, my initial testimony did suggest a preoccupation, almost with the inadequacies of the GAO study.

But, on reflection, it appeared to me that we should focus more appropriately on the results we are all trying to achieve because we are of one mind when it comes to the results, and the results are, quite frankly, zero tolerance when it comes to inadequate care. There is no question that even one incident of bad care in a nursing facility is one incident too many.

I think we are all better served by focusing on how we can best, and jointly, achieve the results we need to achieve in policing the industry so that we can devote our serious attention to the best methods whereby we can improve care in America's nursing facilities. The reason I suggest that, Mr. Chairman, is I looked at the four recommendations enunciated in the GAO report and I looked at the 14 proposals enunciated by the President in the Oval Office last Wednesday.

We can deal with the underlying principles of all 18 of those recommendations. Clearly, the thrust of those recommendations is to deal with poor-performing facilities, and to deal with them swiftly and to deal with them vigorously. Who can take issue with that?

Mr. Hash, in his testimony, talked about whether there should, in fact, be grace periods for, and I quote, "repeat offenders where there is actual harm." I am not sure anyone can disagree with that concept, certainly not the industry I represent.

I think it is important to make sure, as Mr. Goldberg suggested, those who cannot or will not provide the care that is expected of them should not be a part of this industry. Perhaps we should work with them to improve the care, but if indeed they don't get it, then perhaps this industry does not have room for them.

But once we have done that, and perhaps more important than that, Mr. Chairman, is that we have got also to work with those who want to provide quality care, and that can be done only through a collaborative effort between the State and Federal Government, the industry, consumer groups, and academia. Only in collaboration can we actually improve care. These issues that we are dealing with, be they nutrition, or be they pressure sores, are not intractable, but they are difficult and they have to be dealt with across the entire continuum of care.

Noted gerontologist John Morley in the area of nutrition pointed out in a study as recently as last may that in hospitals, 50 percent of elderly patients are malnourished. In home care, 44 percent of elderly patients are malnourished. In nursing homes, 40 percent of elderly patients are malnourished. Does that make nursing homes better? Of course not. What does it say? It says we have a problem that transcends a specific facility or a specific location of care. We have a problem that lends itself to more collaborative efforts across the entire continuum of care.

Nutrition is indeed a very serious problem, and to improve the situation is going to require much more than simply policing, important as policing may be. You have worked with us, Mr. Chairman, in the State of Iowa as we have looked at those peak periods where we have more of our residents who need to be fed. And you discovered, I am sure, to your chagrin, as we discovered to our chagrin, that the regulatory system says even if you wish to bring in volunteers and part-time staff in the facility for them simply to help feed patients, they need to go through the entire training program and become certified nurses aides. Is that not a situation where the regulations perhaps get in the way? But those are the kinds of issues where, I think, through a collaborative effort we can work together to actually improve care.

Another concern I know this committee has is in the area of decubitus ulcers. Well, in the State of California, for example, 66 percent of those residents in nursing facilities who have decubitus ulcers had them when they entered the facility, normally from a hospital. The figure now is down to 9 percent. Does that make nursing homes better than hospitals? Again, not one whit, but it does suggest again that we have programs where, through collaboration, we can actually improve care.

Policing is important. We do want to work with you, with the Congress, with the executive branch on the policing function. We wish to rid the industry of those who will not or cannot provide quality care, but policing is not the same as improving care. I think we have an equal responsibility—certainly, the Government, which is financially responsible for 75 percent of all residents in American nursing facilities, has a responsibility that transcends just policing and we need to work together.

I think, Mr. Chairman, there are examples of how well that can work. Mr. Hash talked about some improvement has been made in the area of use of restraints since the enactment of the Omnibus Budget Reconciliation Act of 1987. I would suggest, Mr. Hash, that, in fact, a 50-percent decrease in the use of restraints is more than some improvement. But that was a perfect example, Mr. Chairman,

about something that can be accomplished when we collaborate together.

We worked with the Government, which had a responsibility to isolate the problem. It has the system and it can do that, and did that very well. We knew how pervasive the use of restraints was, 44 percent in 1987. We worked with academia to find new technologies which could be used in lieu of restraints. We educated our own members, in concert with the American Association of Homes and Services for the Aging, and reduced within a matter of 5 or 6 years restraints by 50 percent, and the figure is still going down.

So while we focus attention, as we must—and you have our commitment to work with you on that—on the police function to make sure we rid the industry of those who cannot or will not provide quality care, I think we have an equal responsibility, and we extend the invitation to the Congress and to the executive branch to work just as hard on improving care because that is where the vast majority of facilities need our help.

Thank you very much, Mr. Chairman.

[The prepared statement of Dr. Willging follows:]

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Official Comments

of

Paul R. Willging, Ph.D.

Executive Vice President

of the

American Health Care Association

before the

Senate Special Committee on Aging

Tuesday, July 28, 1998

Good afternoon, Chairman Grassley, Senator Breaux, and Members of the Committee. I am Dr. Paul Willging, executive vice president of the American Health Care Association. AHCA is a federation of 50 affiliated associations. We represent more than 11,000 non-profit and for-profit nursing facilities, assisted living and sub-acute care providers nationwide.

Senator Grassley, on behalf of the women and men who provide care for our nation's elderly and disabled, let me commend you and the members of this Committee for your long-term commitment to this country's seniors and for being the catalyst that sparked this latest round of inquiry and proposals.

The past week, I have had the opportunity to read the draft GAO report and view the President's announcement of initiatives toward the nursing home industry.

First, I would like to say that the vast majority of our facilities do provide conscientious care. So let me begin by making it clear why I am here today:

- I am here today to speak on behalf of the overwhelming majority of nursing facilities that are meeting or exceeding government standards and that, in fact, are doing a good job.
- I am here on behalf of every administrator who double, triple and quadruple check to make sure that no patient has been neglected.
- I'm here on behalf of every doctor who answers the phone at 3 a.m. and rushes to our facilities to attend to a patient's needs.
- And I'm here on behalf of every nurse and nurse assistant who has learned to feed, clean and bathe elderly people with gentleness, dignity and compassion.

These are the kinds of people who make up our association and who make me proud to be a part of it. These are the caregivers who welcome your involvement. They want to work with you to do even better. And what about the remaining few? While a small percentage, it still involves a large number of elderly people. About that small percentage, something must be done. It will be done. And we want to help you do it.

I recognize that this hearing is designed to focus on recommendations contained in the recent GAO report. While I am not sure the GAO report represents the best scientific methodology, the incidents of suffering GAO reveals are a concern to all Americans.

Let me tell you the AHCA's position :

- No matter how small the universe of bad actors may be, it can never be small enough.
- No matter how few elderly people suffer from neglect or poor treatment -- even if that number is only one -- one is too many.
- No matter how many of our facilities are doing a good job, our task will not be complete until every owner and caregiver accepts the responsibility to continuously improve nursing home quality -- or finds another line of work.

I am here to tell you that AHCA agrees with the principles outlined in the GAO report. We also take the same attitude with respect to President Clinton's recommendations on identifying and eliminating from this field abusive or dangerous people by creating a national criminal background check system. As many of you know, we not only agree with the thrust of these recommendations, we were the first to advocate them.

And let me say simply and directly that when it comes to the issue of abuse and neglect of the elderly, we support a zero tolerance policy.

We need to focus on making poor nursing home providers become good ones. And those facilities that will not comply should simply be shut down.

The GAO report focused on the very serious issue of malnutrition and dehydration in the elderly. We've long advocated the recommendation now before this committee to allow more categories of nursing home employees to participate in feeding our residents. Fighting dehydration and malnutrition among the elderly is a constant challenge, one in which we need to engage as many caregivers as possible.

Last week President Clinton said there is cause for concern "when people living in nursing homes have as much to fear from dehydration and malnutrition as they do from the diseases of old age." Let me say that if any resident is malnourished because he or she has been neglected, then that is a scandal, that is a tragedy -- and that should be a crime.

About this issue, however, let me add a note of caution.

Maintaining nutrition and hydration are challenging tasks for nursing home caregivers for one reason: there are disorders and illnesses common among the elderly that affect their willingness to eat or take in fluids. And this is true whether they are at home, in a nursing home or in a hospital.

The extent of this challenge is borne out in the May issue of Annals of Long Term Care. John E. Morley, a noted geriatrician and long-term care nutritionist, found that more than half of all patients entering nursing homes were already suffering from malnutrition.

We believe that a collaborative effort is critical to improving care for the elderly -- whether that improvement is related to nutrition, hydration and pressure ulcers or to other important caregiving issues. In the past several years AHCA has worked with others to develop nutrition guidelines that are designed to improve caregiving techniques. These guidelines have been helpful, not just for members of our association, but for anyone who cares for an elderly person, whether at home or in a hospital. We would welcome the involvement of government to make these guidelines available to caregivers throughout the country.

Mr. Chairman, we also know that together we can make great progress in the area of pressure ulcers. Although 66 percent of residents had pressure ulcers upon admission to California nursing homes, attentive care reduced the problem to 9% of nursing home residents. We are committed to reducing that number even further.

After all, it was the AHCA that helped identify the high use of physical and chemical restraints in nursing facilities, and we took action to dramatically reduce their use.

I know we can also take the lead among health care providers to improve care in the areas of nutrition, hydration and pressure ulcers.

There are other action-items before this committee that we support, and we want to help you fulfill.

Last year, AHCA -- together with the National Association of Attorneys General -- recommended legislation that would create a national criminal background check system. While many states currently have state background check systems, they fall short of allowing a nursing home to ensure that prospective employees have no record -- in any state -- of abuse or other criminal activity. Therefore, we support the efforts of Sens. Herb Kohl and Harry Reid for moving this legislation forward.

We also support the creation of a National Abuse Registry, and AHCA will help make it work. There is no better way to enforce a zero tolerance policy than to enact a nationwide sanction on abusers.

When it comes to the publication of survey results on the Internet, let me say that AHCA believes that we must provide as much useful information as possible to consumers so that they can make appropriate choices -- that meet their needs or those of their loved ones. For example, providers and regulators in Massachusetts very recently announced an initiative that will allow consumers to access a report card on the state's nursing homes through the Internet. This report card system is easy to understand and helps consumers in the very important process of facility selection. We believe an approach like this, one that provides consumers with a more informed choice, also improves the system.

In fact, when it comes to measuring and monitoring quality, AHCA has developed -- and has made available to our members -- a complete system designed to help providers improve quality. It's rooted in the belief that we must be able to understand which care practices result in clinical improvement and, importantly, customer satisfaction. We have created a software package that allows facilities to collect data on their patients and monitor quality continuously. Facilities can even compare their efforts to other facilities in the field. To put it simply, our system creates an early warning system for facilities to step up quality efforts to protect residents and improve care.

There is an old adage: what you measure you can manage. We don't need standards that measure minutia. We do need standards that effectively help a facility manage -- and improve -- quality care.

What I am arguing for here is refocusing what we measure when we evaluate the quality of nursing home care. At present, a nursing home in which someone has left a stack of canned vegetables on the kitchen floor, can be listed for a violation.

The danger in this kind of book-keeping standard is that it can make nursing homes that do a good job caring for residents appear to be bad. The second danger is that inspectors spend so much time on these minor infractions, they cannot focus on the poor providers, the ones who are failing to deliver good care.

We believe there is a better way to do this.

An inspection report should be designed to look at the results of clinical care. More than that, it should score the level of satisfaction from the only people who are truly qualified to make those determinations -- the residents and families themselves.

AHCA is committed to being on the front lines of quality improvement in long term care.

We are ready to be judged by the people we serve.

I can think of no better way to get to the essence of care. I can think of no better way to put the health and happiness of the residents first. And I know of no better way to let our caregivers measure and improve the quality of nursing homes.

The people we are caring for today are members of a truly extraordinary generation of Americans.

The generation that came of age during the Depression.

The generation that fought and won a World War.

The generation that made America prosperous, conducted a civil rights revolution, put a man on the moon and won the Cold War.

These are the people we serve today.

We want to work with you to do right by them.

The CHAIRMAN. Thank you, Dr. Willging.

I am going to ask you to start.

Senator BREAUX. Well, I thank very much the panel for making the presentation.

Let me ask the staff, if they would, to give me that pie chart on California again. Just put it back up.

Dr. Stone, with all due respect to you and your profession, you must think that I am an idiot or that I haven't been here for 2 days. Your testimony sort of suggests that what they were looking at in California were psycho-social problems out in the industry. The problems I heard yesterday were not psycho-social; they were bed sores, they were people who were physically abused, they were forgery and falsification of records. That has nothing to do with psycho-social aspects of nursing homes. This is not rocket science. This is people who have not been given adequate physical care in nursing homes. That foot depicted on the chart is not a psycho-social problem. That is abuse.

If you look at what the GAO and Dr. Scanlon, sitting next to you—how they set up these categories, these categories are pretty severe. If California had a third in that category which—I can't quite see the end; if you would push over the picture a little bit further. The 30 percent caused death or serious harm, and what Dr. Scanlon says that means is "caused death or harm" represents any Federal deficiency that the survey has classified as constituting immediate jeopardy or substandard care in California deficiencies of improper care leading to death or imminent danger or probability of death, intentional falsification of medical records, or material omission in medical records. That is not psycho-social studies. I mean, 30 percent of your nursing homes, they say, fall into that category. That is obscene.

Dr. STONE. What I am saying is the largest percentage of the survey process is still on the psycho-social aspects of what is going on in the facility. The drill-down stuff that Dr. Kramer was talking about and you were talking about is, yes, we do have parts of it that are medical, but not as much of it is medical. So when the surveyors in California—it was brought up earlier, how come they didn't pick up these things? A good part of what they are doing is devoting their time to the psycho-social aspects of the survey process and not as much to the other medical aspects of it.

Senator BREAUX. The second category is 33 percent, a grand total of 63 percent. The second category they say caused less serious harm represents Federal violations constituting actual harm, but not immediate jeopardy or substandard care, and California violations that have a direct or immediate relationship to the health, the safety and the security of the resident. We are not talking social; we are not talking about psychological problems. We are talking about actual harm to a patient. How can you say they studied something wrong here?

Dr. STONE. I am not saying they studied something wrong. I am saying that they hadn't devoted as much time to the medical aspects of it.

Senator BREAUX. They devoted a heck of a lot to the medical aspects, in my opinion. How many more medical findings do you think they would have to find for you to say, well, they did a good

job looking at the medical problems? I don't understand where you are coming from. Why can't you address the medical problems that the study found? Give me some information to tell me that is not true.

Dr. STONE. Well, what I am saying is that there are parts of what they are assessing that I would not have necessarily, given the level of severity you are—an example in one of my facilities: one of the facilities was cited for the ladle that they were using for the soup being too large.

Senator BREAUX. Well, let me tell you, that doesn't fit in the category of the 30 percent that says it may cause death or serious harm.

Dr. STONE. No. That was in the 33 percent that was "caused less than serious harm."

Senator BREAUX. Dr. Scanlon, comment on that.

Dr. SCANLON. That facility may have been cited for a ladle that was too large, but it also was undoubtedly cited for some other factor in the care process that led to less serious harm. In the category that was orange, there was actual harm to a resident that had to have occurred before those citations were imposed.

I think we are confusing here the issue of the surveyors and what surveyors may find with the care that homes are providing. This is a reflection of the care that homes are providing.

Senator BREAUX. Well, Dr. Stone, you know, maybe I am wrong, but my impression of your testimony is that you are trying to talk about something else, which maybe a legitimate subject to talk about. But we are trying to talk about the actual physical care of people in your 1,300-some-odd facilities, of which 63 percent are said by this study to have some severe problems.

I wish you would have addressed this and told us that this is not true, and instead you want to talk about something that is really, in my opinion, not directly related to that.

Dr. STONE. Also, by looking at that heel up there, I can't tell you that there was abuse on that particular case. As I was talking about in my testimony, what we are dealing with is a multiplicity of issues that were going on with patients. To say that by looking at that heel I can say that there was poor care in that facility is impossible.

Senator BREAUX. Let me ask the industry to comment. The administration has come out with a number of recommendations that they have spelled out and I would like to ask, in general, if you can comment on what they have recommended.

Nursing home inspection times will be staggered. Mr. Goldberg.

Mr. GOLDBERG. I think it is an appropriate recommendation, absolutely.

Senator BREAUX. Dr.—I am going to get your name correctly.

Dr. WILLGING. Dr. Willging.

Senator BREAUX. Dr. Willging.

Dr. WILLGING. We have no problem whatsoever with that recommendation. Indeed, the law currently requires quite vigorously that they be staggered, that they cannot be predicted by the facility. We certainly did not object to that when it was first inserted in the law in 1987. We certainly do not object to that today.

Senator BREAUX. Stronger enforcement actions. HCFA will first require that nursing homes found guilty of a second offense for violations harming residents will have sanctions imposed and not receive a grace period. Mr. Goldberg.

Mr. GOLDBERG. I am not sure exactly, but if it is a repeat violation, absolutely.

Senator BREAUX. Dr. Willging.

Mr. WILLGING. As I suggested in my testimony, Senator, we have no objection to the repeat offenders where there is actual harm, quoting again Mr. Hash.

Senator BREAUX. Continuing development of the Minimum Data Set, HCFA will use data to assess nursing home performance in such areas as avoidable bed sores, et cetera.

Mr. GOLDBERG. I think this is one of the most positive signs coming forward. What we are getting at is a benchmark by which to look at the assessment of the person coming in and at the outcome of the care. I think we are going to have tremendous information to begin to focus on the homes that are really doing their job. So we would support this tremendously.

Senator BREAUX. Dr. Willging.

Dr. WILLGING. Actually, I would agree with Mr. Goldberg. That is perhaps one of the best recommendations, along with the recommendation number 14 by the President that we have to look at new ways of measuring care. The system we currently have is totally inadequate. It measures process. It doesn't measure care, and I think that is what Dr. Kramer was speaking to. We have got to look at what actually happens to the resident.

We have a system today, Senator—if I could just put one statistic on the table which shows how badly the system works, you have a concept called substantial compliance. People are reviewed, facilities are reviewed. They are either in substantial compliance or they are not. In the States of Michigan and Wyoming, only 5 percent of facilities are in substantial compliance—5 percent—in the State of New Mexico, 65 percent, and in Kentucky 60 percent.

Now, do we really want to believe that they just don't know how to survey in New Mexico and Kentucky? Do we really want to believe that all the bad facilities are in Michigan or Wyoming, or is there perhaps something wrong with a system that purports to measure quality and actually measures process?

So we are absolutely right on with that recommendation. Let's start measuring quality if we are talking about measuring quality. Let's start looking at what is happening to residents, and let's start looking at patient and customer satisfaction as well.

Senator BREAUX. Is it a problem that you are getting different results because different States do it themselves? Is that an argument for more detailed Federal guidelines?

Dr. WILLGING. I think we have a problem where there are probably 4,000 separate definitions out there, Senator, as to what constitutes a deficiency because the Federal Government, when it produced the regulation back in 1995, did not deal with scope and severity where it should have, namely when you are trying to decide whether this is or is not a deficiency. They dealt with the concept of scope and severity only when it came to which penalty should be applied.

Only if you put the definition up front are you going to get rid of that incredible variation, and we need a system we can, in fact, find predictable. I think consumers want a system that is predictable. The industry wants a system that is predictable. The way to do it is focus on outcomes. A decubitus ulcer is a decubitus ulcer is a decubitus ulcer. It makes no difference what State you are in; it is there, it is measurable. You may still want to know whether it was avoidable or not. Sometimes, they aren't.

But I think a system that actually focuses on care is better than a system that focuses on process. Now, HCFA will tell you their system focuses on outcomes. Yet, if you look at the top ten deficiencies, the top deficiencies cited every year, they are mostly process. In the area of nutrition, they don't cite weight loss as No. 1 in the citation pool every year. It is the storage of food, the storage of food. That is not outcomes.

Senator BREAUX. Mr. Hash, they say you are missing the point. Can you comment on it?

Mr. HASH. Yes, Senator. I think I would agree, in part, with what Dr. Willging has said, which is that we need to concentrate on the quality of care and the care processes in the institution in order to make sure that, over time, conditions that are identified are dealt with through the care process in an appropriate way.

I would take issue with the fact that we haven't given out proper guidance in terms of recognizing what deficiencies are or categorizing them properly for sanction activity. I think the guidance is ample. Obviously, in the area of the clinical examples that are in the GAO report, part of our initiative is to step up our intensive review of those kinds of conditions involving pressure sores, malnutrition, dehydration, or resident abuse, and to make those the focal point of the sample of patient records that our surveyors examine.

Senator BREAUX. Are you all going to be consulting and having sit-down meetings with the industry on these new proposals to try and see if everyone is speaking the same language?

Mr. HASH. We are, Senator, and we are also doing the same with State survey agencies, with our regional offices who have the first-line oversight of Federal enforcement. All of these folks need to be involved and be clear about what the new policies are and how they will be applied. We want to take the uncertainty out of what kinds of behavior within the nursing home will, in fact, result in a swift and certain penalty.

Senator BREAUX. You all are willing to work with them in helping develop this?

Mr. WILLGING. We look forward to the invitation, Senator.

Senator BREAUX. I cannot overemphasize how important that is, instead of talking at each other or doing legal memos back and forth, to actually sit down and, face to face, discuss what you are trying to get accomplished, Mr. Hash, on behalf of HCFA, and what you all need to know in order to be in compliance; Otherwise, it is not going to work and we will be back here next year with Senator Grassley getting me to come all day long for 2 days in a row.

Mr. GOLDBERG. Senator Breaux, if I might, I think we are heading into a new age, a new age of the MDS. We are just in the process of technologically implementing it. And speaking from the in-

dustry standpoint, you have to give some credit to the Department of Health and Human Services in the development of the MDS.

This is an instrument that is going to require complete, comprehensive resident assessment. It will establish a benchmark by which you can really start measuring the outcome of care. We have never had such an instrument, and as an industry representative we think this is a major improvement. It will be a tool by which the surveyors can come in and really start seeing what is happening. I would hope that we would come back here a year from now and be able to demonstrate that care is improving. Your point is well taken.

The CHAIRMAN. Let me follow up on the point you just made about the MDS, just getting around to making it an effective tool. We still heard about all the falsification yesterday that goes into this, so what do we do about the problem of falsification?

Mr. GOLDBERG. First of all, we have to assume that the nurses and the social workers and the physicians doing the assessment are true professionals. If they misrepresent the truth, that is fraud. I think then you should bring the Justice Department, the State attorneys general and all force of law to prosecute and put them in jail or strip them of their license to practice. Most of the professionals I know want to do the very best job they can, follow the standards that are identified in OBRA of doing a comprehensive assessment of the people. If they are misrepresenting facts, that is fraudulent behavior.

Dr. WILLGING. Mr. Chairman, that is a very important statement. Let's not throw the baby out with the bath water. We are so proud that the long-term care industry has the most powerful data base of any health care sector in the country. Yes, I would agree with Mr. Goldberg, fraud is fraud. Anyone who is fraudulently misusing the MDS, submitting falsified data, should be brought before the bar of justice.

There are other problems with MDS we can work on. It takes up to 4 hours of nursing care that could be spent at the bedside to fill out an MDS form, but let's make sure we fine-tune it. Let's not get rid of it. Let's not, in fact, lose what is an extremely valuable tool.

Senator BREAUX. That is my final point, too. I pointed out yesterday that a paper in New Orleans, a survey in Louisiana—there is a critical shortage of health care workers. We can pass all the best rules in the world, but if you can't find quality people to implement them, you know, we are not going to be able to make this work. We have 2,000 vacancies in the health care industry in Louisiana, and I am sure every State has the same problem. You just can't find the people that you need to do the work that is being required. That has got to be a real serious problem.

Thank you.

The CHAIRMAN. Thank you.

First of all, in regard to the falsification, I think we were finding out yesterday that was being done by people higher up the ladder than just that deliver the care. So, that is something you have got to consider when you said, well, you have got to have people that fill these out correctly.

I also would accept your invitation to make sure that there is prosecution of people that are falsifying records, and that would

bring me to a subject dear to my heart, the False Claims Act. As you know, the False Claims Act was recently used successfully to address quality of care problems in two nursing homes in Pennsylvania. From the testimony that we had yesterday as well as today, it would be no exaggeration to say that there are some, perhaps many, nursing facilities making false claims to the Government. The False Claims Act might be a good tool for decisive action against those nursing facilities, that small percentage that you talk about, that might be providing substandard or even life-threatening care.

You indicated that you would support decisive action against such facilities. Are you prepared then to state for the record that the False Claims Act and the related qui tam provisions would be a good way to make sure that those homes that you characterized as a small percentage are brought into order?

Mr. GOLDBERG. Are you talking to me?

The CHAIRMAN. Well——

Dr. WILLGING. I think the Government needs to use the tools available to isolate those who are truly violating the law and not subject to the same kind of deference that the vast majority deserve. I think there is always the question of where that is, in fact, drawn, the specific line.

I will give you one example, Mr. Chairman. There is a case currently going through the courts in the State of California. It is called the *Lesperance* case. The argument by plaintiff is that being out of compliance, simply being out of compliance, is what the lawyers refer to as negligence per se, OK?

Now, what happens to the facilities in Michigan, where 95 percent are out of compliance? Are we really willing to suggest that all of them are guilty of negligence per se, and therefore should be subjected to something like the False Claims Act? I don't think—and I know of your support for the False Claims Act and I know how sincere it is, Senator, but I think neither you nor we nor anyone would suggest that without protections—without a system that does truly isolate those who should have the full burden of the law brought on their backs, we want to be very careful where we draw the line, and I think this issue of compliance is another good example. Simply being out of compliance does not mean you are defrauding the Federal Government, even though some would suggest it does.

The CHAIRMAN. Attorney General Reno has told me that they are not going to prosecute anybody unless there is fraud. They aren't going to prosecute them for making honest errors.

Dr. WILLGING. If there is fraud, which, by my definition, is intentional, it should be prosecuted.

Mr. GOLDBERG. Senator, I am not an expert on the False Claims Act, but what I do know is when someone is intentionally altering or misrepresenting intent and it causes damage or harm or misappropriates funds, I think all forces of law, whether it be the False Claims Act, the State actions, whatever, should come and correct that situation as soon as possible. It is unacceptable.

Mr. HASH. If I might, Mr. Chairman, I would like to say that you may have noticed that a part of our initiative involves a couple of things that relate to your concern. One is with regard to just the

basic integrity of the information that is reported by nursing homes through the Minimum Data Set, we are going to audit that data to make sure that it can be verified and is accurate.

In addition, we are working with the Inspector General's office at HHS and with the Department of Justice so that law enforcement officials can actually work with the surveyors to help them identify and make judgments about when it is appropriate to refer fraudulent activity to the appropriate law enforcement agencies for investigation and, if appropriate, prosecution under Federal civil and criminal statutes.

The CHAIRMAN. Dr. Willging, did your organization support the McCollum bill that was pushed by the American Hospital Association that would gut the False Claims Act?

Dr. WILLGING. We have been working with the Hospital Association. That was prior, however, to the statement you made and the Attorney General made that if the criterion is indeed willful, intentional defrauding of the Federal Government, that does put parameters around the False Claims Act that, quite frankly, I think we would want to take a look at in terms of our position. If we can be assured that the False Claims Act is indeed being oriented as the Attorney General has suggested toward those who have intentionally and willfully defrauded the Federal Government, I think that makes it a different issue altogether.

The CHAIRMAN. Willful and intentional is not a requirement of the False Claims Act.

Dr. WILLGING. I believe, though, that that was what was discussed in your comment that the Attorney General said if it is fraudulent, it is intentional.

The CHAIRMAN. The point is that she is not going to prosecute unless there is fraudulent—well, no. She is not going to prosecute for honest error. I guess I would suggest to you that I think I have had a reputation over a long, long period of time working very closely with nursing homes and nursing homes associations, and probably on Medicare matters even more closely with the American Hospital Association. I told them so many times when they were worried about this or worried about that, when they were trying to gut the legislation that has been so effective going after fraud in America—I mean, after all, $4 billion has come back to the Treasury. It has been estimated that $250 to $350 billion of fraud we haven't had because it is a deterrent.

I said I know what the Attorney General said, I know what my intent is, and you should have confidence in those of us who have been trying to help you stay on the straight and narrow for a long time, not to go around behind our back and eliminate the most effective tool we have particularly when you are sitting here saying that we are in a situation where you agree that we ought to go after these people.

Well, I will go on to some other questioning of other members here as well. Mr. Hash, the situation in California nursing homes that is documented in the GAO report obviously didn't happen overnight. In fact, I am sure that it was years in the making. Could you tell me why HCFA, the agency with oversight responsibility, was unaware of the situation in California? In other words, where has HCFA been?

Mr. HASH. Yes, sir, I will be happy to respond to that. As I indicated in my statement, our administration published in 1995 the strongest regulations on the enforcement of the 1987 OBRA requirements in the history of Medicare and Medicaid. We started out with an enforcement activity at that time.

It has obviously been our view from the beginning that this is an iterative process, one in which we are going to continuously improve the survey and the enforcement process. We set about to start evaluating our own results from the survey process. Our report which we released to the Congress last week was a couple of years in the making, as you know. It was a year later than it was requested, but it also indicated, among other things, that while progress had been made in a number of areas, there were serious problems remaining, particularly in the areas that were also highlighted by the GAO report.

That prompted us as we were going through the preparation of that report, to begin the second phase of our enforcement strategy. Beginning this past spring in our budgetary process, we put forward a request to the Congress for additional resources for the upcoming fiscal year in anticipation of a stepped-up and a strengthened enforcement effort under the nursing home law. So in that regard, we have been planning this process.

What we released last week in terms of our initiatives, Senator, I don't think is the total answer either. I think we need to see the results of those efforts and if, in fact, they are proving to be inadequate in any respect, we need to come back and revisit them again because this is an issue we have to continue working on. The kinds of incidents that are reflected in the GAO report are not acceptable and do not represent the kind of dignity and compassion that nursing home residents are entitled to.

The CHAIRMAN. In your testimony you state, and I quote, "The enforcement system under these regulations focused on giving facilities a chance to correct problems and avoid sanctions." I would like to have you elaborate on that premise, but my question would be, in other words, if HCFA had that belief and promoted that belief, instead of recognizing that it, in a sense, by doing this, was being taken to the cleaners by the nursing homes themselves.

Mr. HASH. Senator, I think, as my testimony says, that our approach has been in the area of trying to work with the nursing homes that have deficiencies in order to bring them into compliance, in the best interests of the residents of those nursing homes, as soon as possible. The use of the termination authority that we have under the survey process is one which obviously has not been extensively used. But as you well know, termination is not just a penalty on the nursing home, but it may also represent a true penalty in the quality of care to the nursing home residents who have to be evacuated and relocated.

On the other side of that same coin, I would say experience has definitely taught us that the approach of trying to work with nursing homes for the improvement of deficiencies, at least at the serious level, has not proved that they can maintain sustained compliance. Therefore, part of the initiative that we announced last week was to make penalties and sanctions more certain and sure in an

effort to create the right kind of incentives for nursing homes to quickly move into compliance or out of our program.

The CHAIRMAN. So then we will get away from the philosophy that HCFA ought to be doing its enforcement of the law from the premise that the nursing homes are going to improve their own situation?

Mr. HASH. Well, Senator, I think it is still some of both. I think in many cases, we do want to work with the facility, and identify ways in which they can bring their practices and performances into compliance with the highest standards of quality, not only quality of clinical care, but quality of life for the nursing home resident. At the same time, when there are repeated, serious violations that cause actual harm or immediate jeopardy to the health and welfare of nursing home residents, those kinds of misdeeds should be punished certainly and swiftly.

The CHAIRMAN. Going through your written testimony, I think I was able to pick out at least 25 "we wills," we will do this and we will do that. Now, obviously, the devil is in the detail, so let me ask you, since HCFA has been asleep at the switch when it comes to the residents in California nursing homes, I am convinced that in far too large of a percentage of California nursing homes, residents are in jeopardy. You couldn't end yesterday's testimony without that conclusion.

So I don't want to wait for 2 months or 6 months or even a year for HCFA and the State of California to begin taking corrective action. So please tell me what HCFA is going to do about California specifically.

Mr. HASH. Well, Senator, in regard to our whole set of initiatives, a good portion of them are beginning relatively immediately, meaning by the end of next month or the first of the fiscal year which begins October 1. Those specific kinds of things include a statement regarding our revisit policy for facilities that have been identified as having deficiencies. That if they are serious deficiencies at the outset, they will not be returned to full compliance in the program without a full revisit by a survey team. There has been some question about the policy around those areas and we are clarifying that right away.

We are starting right away at targeting what we believe to be the worst performing nursing homes throughout the country, including some in California. For those nursing homes, we will be conducting a survey every 6 months until those nursing facilities can demonstrate full compliance.

We are also implementing right away our Federal monitoring activities looking behind the performance of State agencies. As you know, the law requires us to examine up to 5 percent of the surveys that are conducted by the State agencies. We are going to be doing that in a combination of look-behind surveys of our own and concurrent surveys where we can, in real time, evaluate the performance of surveyors and actually identify where the training of our surveyors needs to be increased.

Fourth, we are going to put immediately onto the Internet the actual cited deficiencies and the sanctions that have been applied to all nursing homes so that consumer of nursing home services will have access to that information.

Senator BREAUX. On that point—I have asked it before—are we going to be stumbling over each other doing these inspections? I mean, are we going to have the States doing it by themselves with their inspection teams? They license the nursing homes. Are we going to have the Federal Government inspecting as well? Or how do we coordinate so we don't duplicate each other's efforts and stumble over each other trying to do these inspections?

Mr. HASH. That is an important issue, Senator, and in our responsibilities under the law to evaluate at least 5 percent of the surveys that are conducted by the States, we are doing two things. One is we are looking behind by doing an independent survey for some number of them that replicates the State survey in order to compare results and to see about the effectiveness of the State survey.

Second, we are also putting into place with the State survey team a Federal surveyor who will participate in the State survey. The Federal surveyor will evaluate the surveyors and help them also to identify areas in which the surveyors need additional training.

Senator BREAUX. OK.

The CHAIRMAN. As I stated yesterday, from 2:45 to 3:30, we have to recess. So I am going to complete this panel and this hearing today, so I will see you all at 3:30 and I am going to recess for the time being. Thank you very much.

[Recess.]

The CHAIRMAN. I would call our hearing back to order and thank everybody for being patient, and I will continue in my questioning of Mr. Hash.

I have carefully reviewed your written testimony, as well as the President's press release that he sent last week announcing his new initiatives on nursing home regulation. In that review, I sensed an attempt on the part of HCFA to point the blame at the States for failure of overseeing quality of care. I also noted that the administrator, meaning your boss, was quoted in USA Today last Friday as putting the blame on lax State inspectors. She was quoted as saying that it is pretty clear that States need to recommend tougher penalties and be stricter in their enforcement.

I also note that in the first paragraph of the executive summary of the 900-plus pages that are in the report of HCFA, and also what the President released last Tuesday, it states, quote, "As the larger single payor for this care, the Federal Government is responsible for ensuring, one, that the health and safety of one of the Nation's most vulnerable populations are protected, and, two, that the expenditures are prudent."

With this in mind, then, does HCFA dispute the fact that it is the agency that has primary responsibility for ensuring that care is acceptable in those nursing homes for which $30 billion of the taxpayers' money was spent last year and not the States?

Mr. HASH. Mr. Chairman, I want to answer that in the strongest possible way I can. Our whole initiative is predicated, I believe, on the premise that enforcement is our responsibility. Various studies, including the GAO study and our own report that you referred to, indicate that it is our responsibility.

We view the States and the survey agencies as a partner with us. We think there is opportunity for improved performance at the State level. We think there is opportunity for more vigorous oversight at the Federal level. And working together with our partners at the State and with you in Congress, we are committed to improving and strengthening the enforcement process to ensure that every nursing home resident gets the attention, the quality of care, and the dignity that they are entitled to.

The CHAIRMAN. Mr. Hash, thank you very much. You have been saying that you will or have been meeting with industry representatives on the President's proposals, and I presume that these meetings should not result in any major changes in the thrust of the President's recommendations since the industry representatives said that they have endorsed those proposals. Mr. Hash, is that your assumption also?

Mr. HASH. Yes, sir. Listening to their testimony, we obviously look forward to working closely with them. They are an important component in the strategy for making sure that this strengthened enforcement process works effectively.

The CHAIRMAN. Would you be willing to keep me and Senator Breaux informed of the progress of those meetings and what goes on in those meetings?

Mr. HASH. Most definitely. As I indicated, Mr. Chairman, it is not just meetings with the industry. We are going to be meeting with nursing home advocates, with our State survey leadership, and with our regional office people. All of this is designed to make sure that our efforts are understood and that people are committed as we are to raising the bar of performance for nursing homes with respect to quality.

The CHAIRMAN. Dr. Stone, I would like to ask you some questions. Yesterday, we heard testimony from a physician specializing in adult care who is currently the medical director of a nursing home in California. This doctor testified that pressure sores are avoidable. Interestingly, you state in your testimony, and I will use your words, quote, "It appears once again the assumption has been made that all negative patient outcomes, such as decubitus ulcers, malnutrition, incontinence and dehydration, are caused by lack of, or inadequate implementation of care interventions, and that the nursing home providers of care are to blame," end of quote.

So let me understand what you are trying to say. Is it your position that pressure sores are inevitable and not avoidable?

Dr. STONE. There are some pressure sores that are inevitable. If you have a person who is at the end stage of their life and who has elected to not eat or is at a point in their life where they have said earlier that they want no other interventions—i.e., a tube in their stomach or into their nose—they are not going to get adequate protein to heal and there will be some of those cases where a decubitus will happen before they pass away.

The CHAIRMAN. I know that geriatric medicine is not an exact science, but don't you think that the finding that 30 percent of California nursing homes put their residents at serious risk of harm, which equals about 40,000 residents, is extraordinarily high?

Dr. STONE. That is high.

The CHAIRMAN. Dr. Willging, you presented two written statements to the committee. One came before the President's announcement last week, the other came afterwards. These two statements are as different as the difference between night and day. I have questions related to both statements because there is important material in each that deserves the committee's attention.

In your original written testimony, you criticized the General Accounting Office report very roughly. Specifically, you criticized its methodology and absolute integrity of the report. Please tell me why you are willing to accept the recommendations of the GAO report if the report is so poorly done and the conclusions thus, by implication, suspect.

Dr. WILLGING. It certainly became clear to me, Mr. Chairman, that the focus should be on the results that we are all trying to achieve. While I had, and I continue to have some questions, some of which Dr. Scanlon has referenced in his testimony regarding the nature of the methodology, more important is the recognition both in terms of the recommendations made by the GAO as well as the recommendations made by the President in his press conference last Wednesday that our focus probably should be not on any specific methodological differences in terms of the research that leads us to the same conclusion, namely that any instance of inadequate care is one instance too many, that our policy should be a policy of zero tolerance, and that we would much prefer to spend our time working with this committee, working with the Congress, working with Mr. Hash and the Health Care Financing Administration to appropriately implement the recommendations that have been made. As you pointed out, Mr. Chairman, we all agree with the general thrust and principles underlying those recommendations. Let's devote our time to dealing with implementing them effectively.

The CHAIRMAN. Well, let me say that I want to think this through with you. I think it can be confusing if we don't really pin it down. You think that the GAO report was poorly done and completely disagree with its conclusions that quality of care in a pretty large percentage of California nursing homes is poor, but yet you accept the GAO recommendations.

At places in your testimony, you seem to indicate that we need to get away from heavy-handed, intrusive regulation, but you support both the President's recommendations and the GAO's, both of which would move us in the direction of tightening up oversight and enforcement. That is what I would like to have you help explain the difference of views there, if it is a difference of views.

Dr. WILLGING. I don't think heavy-handed and intrusive are necessarily the same as tightening up. I have, again, listened very carefully to Mr. Hash's comments, who has, in effect, said part of the, quote, "tightening up"—a very critical part of the tightening up that the Health Care Financing Administration has in mind is to make sure that repeated, serious deficiencies that cause actual harm should, in fact, not have a grace period, should be immediately dealt with in terms of the remedies available to the Federal Government. If that is tightening up, it is tightening up that I think we can accept.

We will be engaged, obviously, in discussions as to the exact meaning of those words. But how could I, how could anyone, suggest that those who are guilty of repeat violations that actually harm residents in these facilities should be essentially given a grace period? I think that that is the key issue we need to deal with and I have no difficulty accepting the invitation that has been offered by Mr. Hash and the admonitions by both you and Senator Breaux that we work together to make sure we accomplish that expeditiously.

The CHAIRMAN. At one place in your testimony, you state this, quote, "We could have the greatest regulatory bureaucracy in the world and still not improve the quality of care," end of quote. On the other hand it also states that, quote, "It is important for the facilities which are consistently poor providers to be subject to the full weight of regulatory process until they improve care and are precluded from providing care."

So could you clarify, please, your position regarding the relationship between effective regulatory oversight and quality of care as it applies to nursing homes, and does the regulatory framework ensure good quality of care or does it not?

Dr. WILLGING. I would be happy to deal with that issue, Mr. Chairman. I think that I have stated and would emphasize again that the policing function, the regulatory system designed to isolate poor care, is a critical, undeniable function. Responsibility for that function lies in the hands of the Federal Government and its State partners, and we wish to support that.

We wish to make sure in our no-tolerance policy that we are isolating the bad providers, working with them where appropriate, but where they either cannot or will not provide the kind of care America's seniors have the right to expect, we remove them from the program. But the only people who can improve care are those within the facility, and policing is not the same as actually working collaboratively to improve care.

We have seen what can happen when, in fact, we work collaboratively to improve care, not just to police, not just to isolate, important as that function is. But I think the whole approach to the use of restraints was a function of collaboration with all of those partners, not giving up their respective responsibilities. I am not suggesting that for one moment HCFA should do any less policing. We may work with them in terms of how that can be more efficient, but that is a critical function.

But I think we have proven in the area of restraint use we can do even more to improve care with the 90, 95 percent of facilities who want nothing more than to improve care by working with them, providing them the information, providing them the resources. That is what I would hope we would spend an equal amount of time on.

The CHAIRMAN. Your organization represents the thousands of nursing homes and other care providers, and in regard to some testimony we heard yesterday, we heard about how the MDS data sheets are falsified and often paint a rosy and inaccurate picture of care delivered. You have staunchly defended your nursing homes and stated that there are only a few bad apples, so I would like to ask a question about the message you might get.

Why wouldn't the same nursing homes that are misleading the Federal Government about their performance also be misleading you and giving you a false sense of confidence?

Dr. WILLGING. When it comes to falsifying records, Mr. Chairman, you will get no argument from me. That is where zero tolerance certainly has the same impact. There is no excuse for falsifying records. There is also no excuse for not having an independent audit function to make sure that doesn't happen. I am sure this is of interest to everyone at this table and at your side of the table.

So much depends on the adequacy of the information. Our whole approach to a revised method of measuring quality of care depends on such things as the MDS. We are not served by falsified records. In fact, if you look at the ultimate purpose of these kinds of tools, which is to provide the information and the data to nursing facility operators so as to help improve care, you can't do that if the record put on the table is falsified. So I could not support any more than I do the concept of dealing very, very vigorously with those who would falsify records.

The CHAIRMAN. I think you are telling me that you could also receive an inaccurate picture. If you have people that are defrauding the Federal Government in their reports, you could also receive an inaccurate picture, right?

Dr. WILLGING. Absolutely. If the care reflected in your reports to the Federal Government is rosy, but the reports you have submitted to the Federal Government are, in fact, falsified, of course, that paints a totally different picture.

The CHAIRMAN. Mr. Goldberg, you stated that the surveyors know which are the bad apples and the bad facilities. Would our other association witnesses agree with that? Would you agree with that?

Dr. WILLGING. I think that we can, in fact, isolate the bad actors.

The CHAIRMAN. OK, and you, Dr. Stone?

Dr. STONE. The same with the American Medical Directors Association.

The CHAIRMAN. Yes. Would it be correct to conclude—

Dr. WILLGING. If I could, Mr. Chairman, I think we can isolate them even better, though, if we move even more vigorously toward an outcome-oriented approach such as that described by Dr. Kramer.

The CHAIRMAN. Would it be correct to—and this would be to all three of you—conclude that HCFA knows or could know which the bad facilities are? In other words, the bad actors, the bad apples, get rid of them? I would like to ask each of you if it is your view—you say that we kind of know who they are—would you expect that HCFA would know?

Mr. GOLDBERG. If I might, I am not sure they know at this moment. I think the use of the MDS and the ability of looking at what has happened to patients over a period of time—if that data is computerized and made available—will allow HCFA to have that capacity. I think they are moving in that direction. I am not sure they have that right now because there is such a mass of data. It is sometimes slow coming in from the States. They don't always have it available. The data processing capacity isn't always there

in a timely fashion. They are getting there, and I hope they are getting there very quickly.

Dr. WILLGING. I would agree with Mr. Goldberg. I think that what is not at issue is the Health Care Financing Administration's commitment and sincerity in looking for the bad actors. I think the problem is they are confronted with the inadequacies of the same system that we are confronted with. How do you know where the bad actors are when your system tells you that 95 percent of the facilities in Michigan are not in compliance, and yet only 35 percent of the facilities in New Mexico are not in compliance?

That is the dilemma we have when a system is based largely on process and not on outcomes. I think it is much more predictable, to use Mr. Hash's terminology, if we begin to focus on what really counts, namely the outcomes, what is happening to the resident. Then we will perhaps not see these widespread disparities and it will be easier for HCFA to know exactly who are the bad actors and who are not.

Dr. STONE. I would like to echo that, but add one thing.

The CHAIRMAN. Yes, go ahead.

Dr. STONE. It has always been sort of a problem for me and for physicians in general in long-term care that we have very little input in the survey process. For that matter, survey tends to avoid talking to the physicians who have patients in the facilities, and I think it would be to surveys' advantage and to the facilities' advantage to have more of a medical frame of reference when they are assessing the quality of care in facilities. These are patients. Yes, they are residents of a facility at the same time, but they are patients, and that communication seldom occurs under the present system.

The CHAIRMAN. Well, Dr. Harrington said on the last panel that the OSCAR data that we have could lead us to the bad actors. Is there any dispute on that?

[No response.]

The CHAIRMAN. It also sounds to me from 2 days of hearings we have had that there is certain activity that needs to be reported to the Department of Justice and it isn't being reported to the Department of Justice. Why not? Could any of you help me on that? I mean, there are bad actors out there. We know that things are wrong.

Dr. WILLGING. Certainly, I think all we can do is suggest that anyone who has such knowledge of indictable crimes, that things should be reported, and reported immediately.

The CHAIRMAN. Mr. Hash, maybe I should ask you that.

Mr. HASH. Mr. Chairman, as we talked about in our initiative, one of the key elements was better preparation of our surveyors to identify behavior or activities in nursing homes which violate Federal either civil or criminal statutes. To make appropriate referrals to law enforcement agencies to investigate those allegations and, where appropriate, to pursue prosecution under Federal civil or criminal statutes.

There is obviously an opportunity to make improvements in the training of surveyors to better alert them and sensitize them to these kinds of issues so that they become a better source of appropriate referrals to law enforcement agencies.

The CHAIRMAN. Mr. Hash, are you able to act upon this knowledge that they say is here? Some say it is here and some say it will be very shortly available. Maybe I ought to ask you, do you have it now?

Mr. HASH. As of June of this year, we began receiving from the States the Minimum Data Set, which is the clinical information that derives from the assessment of patients at the time of their admission to a nursing facility. That data is now being submitted in an electronic form and it will enable us to better focus our survey activities and to do a host of other activities that depend on having individually specific information about patients in nursing facilities. We are just now getting the first wave of that data.

The CHAIRMAN. What about in the most extreme cases? Would HCFA communicate that to DOJ for possible false claims action or for possible criminal action?

Mr. HASH. If information comes to our attention that is a credible allegation of a violation of Federal civil or criminal law, we would refer that allegation for evaluation and investigation by either the Inspector General of the Department of Health and Human Services or the Department of Justice.

The CHAIRMAN. I have no further questions. I want to ask Senator Breaux if he has questions.

Senator BREAUX. Yes, I would like to ask just a couple. Thank you, Mr. Chairman.

One of the recommendations that we have heard from some is that we ought to use the Joint Commission on Accrediting Health Care Organizations, JCAHO, which already does the work with acute care hospital facilities and that do it for some nursing homes. Why don't we just accept their inspections and deem that you are in compliance as a result of what JCAHO does? Dr. Willging, what do you think about that?

Dr. WILLGING. I have to often ask myself what is it about the nursing facility industry that lends itself to a totally different approach than we take to all other health care providers, hospitals, home care agencies, and the like. I understand what the Health Care Financing Administration has suggested in the report that was delivered by the President last week. They allege that after having reviewed JCAHO examinations of nursing facilities, they found areas that, in fact, they caught but that the JCAHO did not catch. I didn't see the converse of that, how many things had the JCAHO caught that the Health Care Financing Administration has not caught.

I guess what I am saying is what is it about this situation where there is such an adamancy against testing the concept? What is it that will prevent us from even taking the very best facilities, those that are reputed to have, in fact, been delivering stellar care, without deficiencies, for 20 years uninterrupted, and we can't even test these new systems on those?

Senator BREAUX. Specifically, though, what about the use of JCAHO as an accrediting——

Dr. WILLGING. Deemed status, I think, is something that should be tested, at least. We talk about the unavailability of adequate resources. Why do we feel that we need to have government itself review each and every single facility? There are, after all, conditions

that could be put on these use of JCAHO which would absolutely protect the residents in those facilities.

I don't think we should be endangering residents so as to test the concept of using JCAHO, but why is it we can't construct some kind of a demonstration where we do protect the residents? So I would say that I have to disagree recommendation that they are unwilling even to test the concept.

Senator BREAUX. Mr. Goldberg, what is your comment?

Mr. GOLDBERG. I think it has its limitations, but I still——

Senator BREAUX. Has its what? I am sorry.

Mr. GOLDBERG. We are in a situation where there are questions being raised, but I think survey and certification is still the rule of the land, and should be. I still think there is a need for some experimentation, of looking at the options that exist through other types of accreditation.

Let me digress just slightly to another related point. I think what is critically needed in this industry is for the industry to begin to self-correct. If I told you that most of us know where the problems exist, I think we need to create a system where the people in the industry themselves start saying that it is unacceptable behavior and that provider doesn't belong in the industry.

One of the things that JCAHO does is to involve the industry itself in a much more direct, reflective role of questioning and evaluating the performance of their peers. I think there is some real value in that approach. I think evaluation also has to involve consumers. I think they have to be equal players in this process and we need to explore options for their participation. I don't think we are ready for all these changes, but having the industry, the administrators, the nurses, the consumers, the hardest, meanest, toughest consumers you can, begin to self-police themselves is an important idea. There is some value in not simply having government come in and do the evaluation. The option at least needs to be explored.

Senator BREAUX. Mr. Hash, what is wrong with having JCAHO deem these nursing facilities accredited? One of the concerns I have is I don't understand how we can accept—I guess we do—their accreditation of acute care hospitals that treat Medicare and Medicaid patients, but when it comes to nursing homes we say no. What is the difference?

Mr. HASH. Senator, we just conducted an evaluation of the merits of recognizing the Joint Commission accreditation program on long-term care facilities, which is reported in our report that was released last week. In that report, we contracted with an outside independent entity to evaluate in a comparative way the application of our State survey and certification process directly in the same facilities with the Joint Commission accreditation program in nearly 180 facilities. In over half of them the State survey and certification process found serious deficiencies that were not found in the Joint Commission process.

Many of those deficiencies referred to clinical situations, some of the very things we have been talking about in the last 2 days here. Our judgment and the recommendation of the contractor was that we would be putting nursing home residents at significant risk if

we were to recognize the Joint Commission program at this point in time in lieu of the State survey and certification process.

Senator BREAUX. Isn't that the same organization that we accept their accreditation of acute care hospitals?

Mr. HASH. It is. They are required—and actually the requirement to recognize them on the hospital side is actually a statutory requirement that was put into the Medicare law in 1965 when the law was first enacted. It is an area over which we have no discretion at HCFA, but I would submit to you that—

Senator BREAUX. Are you all recommending that we change that?

Mr. HASH. We are not recommending that you change that.

Senator BREAUX. That is what I am confused about. How can we have a Medicaid patient that goes to this facility and we have one that goes to another facility—one happens to be at an acute care hospital and one happens to be in a long-term nursing home. We are saying that for this patient on this side we are going to accept the JCAHO accreditation survey and deem them acceptable, but for this patient over here we are not. Are the same people making the surveys?

Mr. HASH. But I think the difference in some ways, Senator, is that the kind of evidence that has been brought to this committee over the last 2 days in terms of clinical problems, quality of care problems, quality of life problems, are not the same kind of problems that folks are bringing to your attention or to other people's attention with regard to hospital care.

I think also the survey on the Joint Commission side is clearly a much more process and structure-oriented document, as opposed to what we have all been talking about here. In the case of these nursing home situations, what we should be concentrating on is the quality of care and the quality of life of nursing home residents.

The Joint Commission has much more a philosophy of consultation and assistance in getting corrections, as opposed to sanctions, which we have found are the things that will work to bringing nursing homes into compliance with the Federal requirements.

Mr. GOLDBERG. One of the things that is important to note is that JCAHO has endorsed the whole concept of the MDS and has a very quality information system through which they are beginning to look extensively at the outcome of patient care. This is very similar to what is going to happen with the Department of Health and Human Services. So I think it warrants at least further discussion, further investigation, to look at what happens when they look at outcomes.

Senator BREAUX. Mr. Hash, does HCFA have an open mind, at least continuing a dialog on this subject?

Mr. HASH. Well, I think, Senator, we would always entertain any new evidence that comes forward that indicates that there are changes in the Joint Commission program that might respond to the kinds of deficiencies that we found in our evaluation of it. We would never say that we wouldn't want to entertain any new evidence, but I think based on what we know now, we believe that it would not be appropriate to recognize them for this purpose.

Senator BREAUX. Maybe Congress did it in 1965, but it seems that what you are basically saying is you don't have confidence in JCAHO. You have the same people, the same organization, the

same umbrella group that is inspecting all of our hospitals in the country. You are saying, well, Congress said it was all right. We are not getting a lot of complaints, so they must be doing OK over here. I would assume that the same medical professionals conduct both surveys.

Mr. HASH. Well, I believe it is a different accreditation program, clearly. One of the questions was, well, why couldn't we just take the hospital accreditation program and apply that for nursing home compliance. The trouble with that is the Joint Commission's hospital accreditation program also does not address the full array of issues that we are required under the law to verify in terms of compliance of nursing homes with Federal standards.

So I think it is fair to say with Mr. Goldberg's remark that if, in fact, the Joint Commission is undertaking a significant revision of their accreditation program, we would like to take a look at that. But based on what we have just completed, which was this side-by-side evaluation, we would find that using the current survey instrument that the Joint Commission uses would put nursing home residents at increased risk for failures in terms of quality of care.

Senator BREAUX. I don't want to belabor the point, but what is the value of JCAHO if the Federal Government, who is paying Medicare and Medicaid bills, does not accept what they do? I mean, what use is it?

Mr. GOLDBERG. What is pushing it right now is that the managed care corporations, the HMOs, many times will look for JCAHO certification to determine whether they will place residents in a facility. We would also argue that the HMOs should also be looking at the survey and certification that is done by the Department of Health and Human Services and by the State agencies. But to some degree that is what is driving that issue right now with nursing homes.

Senator BREAUX. Well, does Medicare or Medicaid or the Government pay for in-patient treatment at nursing homes that only have a JCAHO certification?

Mr. HASH. No.

Senator BREAUX. You would have to have Federal inspection?

Mr. HASH. You would have to be certified, right.

Senator BREAUX. Dr. Scanlon, you had a comment. I am sorry.

Dr. SCANLON. Yes. I wanted to note we have not done an examination of the JCAHO certification process for nursing homes, but I do think it is important to point out the major differences between these types of care in nursing homes and hospitals.

In the hospitals, the quality of care assurance process is strongly reinforced by the fact that physicians are present in the hospital most of the time and that their stake in the hospital is much, much greater than in the nursing homes; Also the fact that families and individuals who are using hospitals are there for very brief amounts of time and therefore you have many, many more people using those services helps assure quality.

In the nursing home, it is a very, very different situation, as you know, and I think that we need to be sensitive to how a JCAHO process will work in that different environment with longer stays, less involvement of physicians, and how it will work with other

processes that we need, such as the complaint process and the ombudsman programs.

Senator BREAUX. Well, I appreciate all of you, and I think I go back to one point I was trying to make. It seems like we can pass all the rules and regulations that we could possibly ever think of and make them into law, but unless we have the right people carrying out these regulations and rules, it is never going to be adequately done. And there is a huge shortage of professionals and people who work in nursing homes.

One witness yesterday talked about INS coming through the nursing homes in California and half the people running out the back door because they are illegal immigrants. But if they weren't there, maybe nobody would be there. Staffing is a huge problem. I know in my own State, the survey I mentioned, there is a critical shortage in health care professionals and that is a problem that we need to be taking a look at. How do we encourage more people to get into these professions? Do we pay them enough? Do we not reimburse you enough to pay them enough? It is a vicious cycle and there is an awful lot that contributes to all of this.

Hopefully, Mr. Chairman, these hearings will—I think they have been very powerful hearings. The testimony we heard yesterday was from very sincere people that are very, very concerned about problems that they have witnessed and have experienced. I think it is incumbent upon us to try and work with both the people in the business, the people who do the reports, the people who run the programs, to try and find out what we may do collectively.

It is not enough for us to blame each other. That doesn't solve the problem. That just sort of illuminates the problem. We need now to kind of put our heads together and collectively come up with ways we can provide better quality health care in this country in all segments, and especially in nursing homes because they really do treat the most vulnerable among us; I thought the lady who made us sit on our hands gave us for a very brief moment an experience that these people have everyday, and all day. So we all have an obligation to really do our very best.

We thank you for being with us.

The CHAIRMAN. Well, Senator, I agree with your analysis that this is kind of just the beginning with the major program and crusade that you and I will have to be involved with. And I can assure that on my part we will, and we have had very good cooperation from you and your staff and other members who have been present. Everybody has been outraged with the situation that we have discovered in exposing these problems. People are interested in exploring why these things happen, and obviously to bring pressure to bear both within the industry and within the governmental oversight to make sure that the job is done right in the future so that we do not have some future Congress have a hearing that reminds us of what I think Dr. Harrington said.

She had been dealing with this in 1975, and you and I started the meeting out yesterday where we showed that this was a major problem in 1986 or 1987 from the newspaper reports and the Institute of Medicine, and also the General Accounting Office even then. So I think proper follow-through is an absolute necessity, and I pledge to you that I will do that and I know from the statement

you just made that you will want me to do it and I will want to work with you to see that that happens.

I think we are done with questioning, but I do have some remarks I want to make at the end. But before I do, in your case, Mr. Hash, I would have maybe four or five other questions I would like to have an answer in writing.

Mr. HASH. I would be happy to provide that, Senator.

The CHAIRMAN. Then for all of you, I may not have anymore questions in writing for you, but other members who couldn't be here for the entire time can submit questions, and we would like to have those returned within 10 days from the time you receive them. We would appreciate that cooperation very, very much.

Mr. Hash, again, this would be a request in writing, but not part of the questions that I didn't get asked orally, and this is one of my earliest questions to you and I think you probably answered it adequately where you were saying what you were going to be doing in the future to see that the President's recommendations were carried out. I did not follow closely enough to see how well thought-out that is in a time-line fashion, but I would like to have from you, in a few days, sort of a calendarized or time-line approach to when certain actions are going to be taken and I would like to have that in time for our printed record so that can be part of this document as well.

Mr. HASH. I would be happy to provide that, Mr. Chairman.'

The CHAIRMAN. Thank you very much.

Basically, for yesterday as well as today, although I thank everybody who was involved with yesterday's hearing, but I just have to say thank you to this panel, the experts that we had on the first panel, particularly the attitude expressed by industry representatives, you folks now at the table, your willingness to work with us, work with HCFA, more importantly probably to work within your own organizations and within your own separate business organizations that are members of your association to make sure that we improve this situation, and also HCFA's commitment to that.

I think we have to acknowledge the good work of the GAO in conducting a telling study on the quality of care in California nursing homes. I suppose I don't do justice when I name just three or four people, but Dr. Scanlon, Ms. Allen, Ms. Curran, and Ms. Avruch, and then other people that I probably have not had a chance to meet who have toiled over this study day after day, and now month after month. So we thank you for investigating what we presented you with last September and October and finding that there is a problem in California nursing homes.

I guess I would thank HCFA for reminding us in this report and the President's statements that there might be something systemic. And, obviously, as I said yesterday, we are going to ask the General Accounting Office to follow up with other States. We are going to ask the Office of Inspector General of HHS to do that as well.

I thank all of you for painstakingly checking and rechecking your analysis in this report, Dr. Scanlon. We thank Dr. Kramer and Dr. Harrington for their dedicated analysis of the quality of care delivered to nursing home residents. I would also speak more specifically to nursing home industry representatives who are here not

just on the panel, but those in the audience as well. There are several points that I would like to address specifically.

I am of the belief that this Nation and your industry do not need any new rules. We do not need any more regulations. We do not need any more reporting requirements. We do not need more papers to be filled out. At the same time, I recognize that the nursing home industry's good-will acknowledgement of a few bad apples and assurances that this industry will cleanse itself, monitor itself, and correct deficiencies itself is simply not enough. I recommend that you work hard hand-in-hand with HCFA and with this committee to remedy the California nursing home situation as soon as possible. Nothing less would be acceptable.

Last but not least, Mr. Hash, I would direct some words to HCFA. You know, it is obvious that what we heard about Mr. Curzon, about Mr. Davis not being fed, about Ms. Espinosa not being turned—that everything that Congress has laid out for HCFA to be doing, HCFA didn't seem to be there. You came before us today and said, yes, there is a problem with HCFA's enforcement. Yes, HCFA needs to improve. Yes, HCFA needs to do better to protect the Nation's nursing home residents. Yes, HCFA accepts the GAO recommendations. Of course, that is all fine and good, but that is all talk.

So, obviously, you have pledged yourself to action, and working with you, if there are any problems you have delivering on what you told us you would do, I hope you will seek help up here on the Hill, whether it is anonymously or whether it is very openly, because wherever you need to help to get the job done, we need to do it because we want this to be the end of HCFA's inaction in this area. And we want to do it right now. We don't want to do it a year from now because there are simply too many mothers and fathers and husbands and wives that are suffering in California.

Therefore, I request that you would immediately implement the no-cost recommendations made by the General Accounting Office. Most of these recommendations, it seems to me, can be easily implemented. I think there has already been testimony and acknowledgement on your part to that. In addition, I would like to have monthly reports from you regarding your implementation of the GAO recommendations. That would be within the confines of the calendarization or priority that you have suggested you can give to me. It is kind of a monthly update to know where we are. That is what I would ask.

Dr. Scanlon, I would ask that the General Accounting Office report to me separately and independently, as well. I ask specifically that you would verify and validate HCFA's representations to the committee regarding its actions, as I have just asked Mr. Hash to do.

In addition, Mr. Hash, please make arrangements to ensure that the term "readily available" regarding people's access to past survey results means just that, not that these results are locked in some nursing home administrator's office. Through this committee, though your work, hopefully through the association's work, through the testimony we received yesterday, we are trying to get families, primarily—and friends and anybody else involved in making decisions on what are the best nursing homes to know about

the conditions of the nursing homes both before someone enters and while they are there. The place to get that information is from these surveys. They can help us know who the bad actors are and who the good ones are and whether you want your person in this place or that.

Those survey results should be very accessible. The people of California need to be able to see who has deficiencies and who does not, and I think it puts a little competition and a little sunshine into the system. That would be why I am asking you to make sure that that gets done.

I hope that you will all, including HCFA, embrace this hearing as a beginning and not as an end. I think Senator Breaux said that better than and more thoroughly than I can and I embrace what he says. There is an unacceptable problem in California nursing homes. People are not being properly fed, repositioned, and given enough water. Some say that what happens is old people die; they stop eating, they stop drinking, and they waste away. I am sure that some do, but many do not.

This hearing is for those thousands of nursing home residents in California who do not want to just waste away. The very idea that elderly nursing home residents are suffering from malnutrition and dehydration unrelated to medical conditions and pressure sores that are avoidable is wrong. We should not stand for it, and that is true for today and it ought to be true for tomorrow and it ought to be true forever.

Let me be clear about my intent here. My committee, in the spirit of what Senator Breaux has spoken about, is going to keep looking at nursing homes. As I have suggested yesterday and today, I have requested additional look-sees from the General Accounting Office and from the HHS inspector general. We need to know, of course, if this problem is isolated to California or not.

The General Accounting Office findings clearly illustrate that residents in far too many California nursing homes are threatened by substandard care. HCFA seems to indicate that the problem is much more systemic—that is what this 900-page report would have as part of its findings—more systemic than we could imagine. I want, and I think we would all want HCFA to take immediate action to fix the problems that the GAO report has uncovered in California, and this committee will vigilantly monitor that.

In addition, I will keep the administration's feet to the fire to ensure that its proposals are more than a window dressing and are meaningfully and immediately implemented. I don't use that "window dressing" word to denigrate what has been done. I have complimented, the President and HCFA and I still stand by that compliment. But I guess time will tell, and I think in the process of our constitutional responsibility of oversight that is the vein in which I make that statement.

I have said publicly how comatose HCFA has been up to this point on this, and we have documented the damage that has been done. This is a self-indictment of HCFA and they have released that, and I think that there is acknowledgement on their part of that.

So I guess I would only say, and hopefully never have to say again, but I would say that this committee on our watch, not just

as one member, the chairman, not just as two members, the Senator and the ranking member, but every member on this committee is committed to making sure that when HCFA hears an alarm like we have heard today that we are not going to let HCFA hit the snooze button in response.

I thank you all very much for your kind attention. Good afternoon, and the hearing is adjourned.

[Whereupon, at 4:45 p.m., the committee was adjourned.]

APPENDIX

Senator Grassley's Top Ten Tips for Selecting a Nursing Home

1. Shop around! Planning ahead will allow you to research and compare different facilities. You will be better prepared to find your loved one a caring, compassionate, and competent facility.
2. Investigate. Evaluate the state's survey of inspection. Each state conducts inspections at least once a year and issues a report of its findings that must be available to the public. It is required to be readily available at all nursing homes.
3. Look for consumer information. A number of consumer organizations representing nursing home residents and their families have made helpful information available on the Internet, including information about deficiencies. The web site address for the California Advocates for Nursing Home Reform is: http://www.canhr.org. Or call 1–800–474–5171. In California, call: (415) 474–5171.
4. Consult the ombudsman. Federal law requires each state to have a long-term care Ombudsman's office with information on all nursing homes. To contact your ombudsman, call the National Citizens' Coalition for Nursing Home Reform in Washington at (202) 332–2275.
5. Make unannounced visits to prospective nursing homes. Use your senses: look, listen, and smell. Walk through the hallways, speak to residents, their visitors, and the nursing home staff. Get a sense of the environment.
6. Look with a critical eye. When visiting a facility, assess the food by its appearance and taste. Check to see that those who can't feed themselves are being helped.
7. Observe how long it takes for residents' call lights to be answered; anything more than 5 minutes is too long.
8. Look for obstacles or puddles left in corridors that could endanger frail residents.
9. When choosing a facility, do not make a hasty decision or succumb to pressure tactics. It's better to wait so that you make the "RIGHT" decision—not a mistake.
10. Trust your instincts.

Senator Grassley's Top Ten Tips For Getting Good Care At A Nursing Home

1. Be involved. Your involvement will make a difference. If you live nearby, visit frequently. Residents whose families visit regularly tend to receive better care than those who do not have visitors. If you don't live nearby, think about appointing a representative to go in your place.
2. Pay close attention to the condition of the resident. Watch for changes. Look for (1) pressure sores, especially on areas that are usually concealed (check feet and heels); and (2) malnutrition (check for weight loss, and skin condition, and see if clothes fit or appear loose).
3. Monitor resident's dental hygiene and make sure it is being attended to. Malnutrition, and other quality of care problems, can sometimes be traced to deficiencies in dental hygiene care.
4. Keep track of the resident's medication regime. Ask for a list of drugs the resident takes, and consult a pharmacist if you have questions or concerns. On average, nursing home residents take between 5–8 different medications daily. Constant monitoring of drug intake can help prevent drug misadventures.
5. Talk with the resident about their care. Remember this is the resident's home. Residents are often hesitant to complain to facility staff, but will be more likely to share with a family member or friend if there are problems. Ask specific questions about meals, bathing, medications, and general treatment of resident.
6. Get to know the staff. Build relationships with care providers. Show appreciation for staff who go the extra mile.

7. Participate in the Resident's Plan of Care Meetings. Be sure the resident's views and wishes are heard and respected. If you cannot attend, send a representative in your place.

8. Protect resident dignity. Learn the Nursing Home Resident Bill of Rights and take steps to ensure that care is provided in a manner that promotes and maintains each resident's dignity. If this is not happening, COMPLAIN! Look for such things as grooming, participation in activities, dining, and whether the staff speaks respectfully, listens carefully and treats your loved one with respect.

9. Monitor the facility's quality performance. Periodically request copies of all incident/accident reports from the nursing home. Ask to see the survey findings of the most recent inspection. Ask the Director of Nursing or Administrator questions about the deficiencies if you would like to know more. Talk to the ombudsman. Get to know the family members of other residents who visit the facility. Subscribe to the facilities newsletter if there is one.

10. If you are dissatisfied or concerned about quality of care, Speak Up! Talk to:

- Director of Nursing
- Nurse Supervisor
- Charge Nurse
- Certified Nurse Aid (CNA)
- Ombudsman
- Survey and Certification Office
- HCFA Regional Office
- HCFA
- Local Police
- Medicaid Fraud Control Units
- Use the qui tam provisions of the False Claims Act.

Kathryn Locatell, MD
Responses to additional questions
August 21, 1998

1) Patient abuse by caregivers is a serious concern in nursing home care. I believe it occurs more often than is recognized. In just the past six months, I have had direct personal knowledge of 3 incidents in nursing homes in Sacramento. I have no doubts whatsoever that the abuse did occur in all three cases. There are usually no witnesses, and the complaints are very difficult to substantiate or prosecute. The better quality facilities will almost always take immediate steps to investigate such incidents, and to allay family members' concerns. All facilities should take any accusations of abuse very seriously, because the population in nursing homes is so vulnerable. However, it has been my personal experience that the poorer quality facilities tend to dismiss accusations in a rather defensive and cursory fashion. I have indirect knowledge of an equal number of abuse cases in which no action was taken at all by the facilities involved; in fact in one case, the aide who actually witnessed the event was terminated, while the alleged abuser faced no disciplinary action.

2) I agree one hundred percent with instituting such a program. I do not think it will eliminate the problem, but it will certainly make it far more difficult for repeat abusers to obtain jobs in nursing homes. Underpaid, undertrained and overworked nurses' aides may often lash out in anger and frustration, while not perpetrating such offenses on a regular basis.

3) I would seek out all possible alternatives to nursing home placement. While a sizable proportion of the elderly population has expressed a preference for death over life in a nursing home, there are usually options for long term care that are more hospitable and home like. As an example, the Programs of All Inclusive Care for the Elderly (PACE) can often offer the disabled and dependent elderly person much more humane and compassionate options for assistance. In my practice in Sacramento, I am fortunate to have a PACE site to refer patients to. I find quite frequently that some combination of community-based long term care options offers a much better quality of life than the best nursing home. Short-term skilled nursing facility placements, however, can be critically useful in maximizing function, enabling the individual to return to a lower level of care. I would advise anyone trying to evaluate quality of care in nursing homes to use their senses in a close inspection of the facilities. I would reject placement in any facility that smells strongly of urine upon entry. I would also reject placement in any facility without having been given several options from which to choose. Often the discharge planners in the hospital will present one choice for the family, implying that this is it, and if you don't take it you will be charged for any extension in the hospital stay. This is a breach of duty on the part of the hospital, and should not be tolerated, in my opinion.

4) "Falsification" of records can be found in almost every record of nursing home care, if close inspection is made. Whether these instances of inaccurate or false charting represent actual, intentional misrepresentation is another, more difficult question to answer. Again, under paid, untrained staff may unintentionally make errors that are understandable. But the severely compromising practice of "adjusting" the records (to use the GAO's terminology) for the purposes of "passing" state surveys is a far more pervasive and reprehensible. Examples of both types of falsifications are frequently found. I have never seen a citation or survey from the state of California that addresses this issue, while nearly every chart contains inconsistencies, between MDS, nurses' notes and ADL charting, for example, that should raise the suspicion of false charting. Thus I feel there are no checks in my state for the accuracy of recorded information. Since the state survey process does not even address the falsification issue, there is no system in place to address this major weakness in the entire licensing and certification process.

5) The appropriate ratio of attendant staff to patient has not been determined in any systematic fashion that I am aware of. It would be an extremely valuable endeavor to devise a system for scoring the care needs of dependent residents that could accurately predict the workload of the staff. For example, 30% of the residents may need only partial assistance with bathing and grooming, consuming less time from the attendant staff, while 70% require total assistance with these tasks, thus requiring more time. Some type of formula that combines the amount of time required to provide adequate care with the proportion of residents needing such care would be ideal, and should be relatively easy to develop. It would be particularly useful to tie such information to MDS data to ensure accuracy and consistency. In my opinion, this is an example of a practical and important clinical parameter that is ripe for study, yet one finds little or no systematic analysis to guide important policy decisions. The typical ratio varies from 6 to 1 to 30 to one, depending on the facility and the acuity of the residents. The notion of the multi-tasking or cross-trained worker in health care is somewhat of a fad at present, and the value of an innovation like this is only as great as the commitment of the facility to truly provide quality of care, and to rigorously monitor and maintain quality. In acute care hospitals, lip-service is paid to these goals, while they have yet to even trickle down to the nursing home industry.

GAO

United States
General Accounting Office
Washington, D.C. 20548

Health, Education, and
Human Services Division

August 20, 1998

The Honorable Charles E. Grassley
Chairman
Special Committee on Aging
United States Senate

Dear Mr. Chairman:

In response to your August 10, 1998, letter to GAO, we have provided answers to questions submitted by members of the Senate Special Committee on Aging that were not asked, due to time constraints, during the July 28, 1998, hearing entitled, "Betrayal: Quality of Care in California Nursing Homes."

1. It is suggested that surveyors simply do not have enough resources to do a thorough job of inspecting all facilities. But we have also heard that even when a nursing home is cited for a serious violation, penalties are rarely enforced. In your opinion, is it a lack of funding or lack of follow-through that leads to this problem?

Our review of federal actions taken against California's noncompliant homes indicates that the Health Care Financing Administration's (HCFA) policies, as implemented by California's Department of Health Services (DHS), are the reasons why penalties are rarely enforced. In particular, HCFA's forgiving stance on enforcement allows homes with a history of noncompliance an opportunity to correct problems without any penalty issued. We did not review whether a lack of funding contributed to this problem. However, even with resource constraints, we believe HCFA and DHS could target their resources to better ensure that their oversight and enforcement efforts are directed at homes with serious and recurring deficiencies, and that policies developed for homes with less serious problems are not applied to homes that have been repeatedly found to have serious violations.

2. Do you believe that what was found in California is happening in the rest of the country?

Based on our work and HCFA's and other studies, we believe that the problems we identified in California are indicative of systemic survey and enforcement weaknesses, and therefore, the problems could be occurring nationwide. GAO is currently conducting a broader review of HCFA's enforcement process and will comment in a forthcoming report on whether similar enforcement problems have occurred in other HCFA regions.

3. It is becoming clear that we already have laws and regulations on the books that would work well if enforced correctly. The President announced a series of administrative actions to improve such enforcement. Do you believe that his proposals will help improve the State survey process? Specifically, which particular proposals do you support? Are there any initiatives not included in his plan that you believe should be?

We believe that the President's proposal included a number of important measures that will help improve the state survey process if implemented in a timely manner. Among his proposals were the following recommendations included in our July 27, 1998, report to the Senate Special Committee on Aging:

- stagger the timing of standard surveys to ensure they are not predictable,
- eliminate the grace period for homes cited for repeat serious violations, and
- ensure that state survey agencies sanction homes with serious violations and that sanctions not be lifted until after an onsite visit has verified compliance.

Other parts of the President's proposal appear reasonable, although in some cases our work did not allow us to evaluate their merit. For example, the President has proposed establishing a national registry of nursing home employees convicted of abusing residents and requiring homes to conduct criminal background checks on all potential nursing home personnel. This proposal would require legislative action to implement. While we have not done work on this topic that would enable us to comment directly on the specifics of this proposal, on the surface it would seem that such background checks could help avoid some problems with potentially problematic employees. Likewise, while we did not examine the performance of homes within chains, the President's proposal to focus enforcement efforts on nursing homes within chains that have a record of noncompliance with federal rules would seemingly encourage these homes and owners to sustain compliance by all affiliated homes.

In some cases, the President's proposals are a step in the right direction, but do not go far enough. For example, we believe that posting individual nursing home survey results and violation records on the Internet could help consumers look for a "good" nursing home, but we believe that this information should also be available in hard copy for those who do not have access to the Internet. Further, the information needs to be provided in a format that will be easily understood by consumers. We also believe analyses of the Minimum Data Set (data from nursing homes on residents' health and functional status) could be useful to assess nursing home performance in such areas as avoidable bed sores and weight loss, but only if additional measures are taken to assure the validity and integrity of the data.

In addition to the President's proposals, we recommended that HCFA's survey procedures be revised to instruct the state surveyors to take a stratified random sample of resident cases and review sufficient numbers and types of resident cases so that surveyors can better detect problems and assess their prevalence. Although this initiative was not specifically included in the President's proposal, we believe that it is an important measure that would help better determine the prevalence of an identified problem and trigger corrective actions when warranted.

4. In addition to enforcement of existing standards, what, if anything, should Congress be doing legislatively to protect patients?

Based on our work in California, we did not recommend that the Congress take any new legislative action. Instead, we believe that better implementation of the existing legislation may considerably improve the survey process and promote better nursing home quality. In addition, we believe that ongoing congressional oversight and monitoring of HCFA's progress in implementing the President's proposals and other provisions in the Omnibus Budget Reconciliation Act of 1987 are an important part of the process that will help ensure that the needs of vulnerable nursing home residents are appropriately and efficiently met.

We trust you will find this information helpful. Please call me at (202) 512-7114 if we can be of further assistance.

Sincerely yours,



William J. Scanlon
Director, Health Financing
and Systems Issues

RESPONSES FROM UNIVERSITY OF COLORADO HEALTH SCIENCES CENTER

QUESTIONS

1) Do you believe that what was found in California is happening in the rest of the country?

While our work with the General Accounting Office examined survey activities and quality of care in two California nursing homes, our previous studies have examined nursing homes in more than 20 other states. We have identified similar quality of care problems in nursing homes in states other than California. We have also found that state survey teams in other states did not detect many of these quality problems.

2) It is becoming clear that we already have laws and regulations on the books that would work well if enforced correctly. The President announced a series of administrative actions to improve such enforcement. Do you believe that his proposals will help improve the State survey process? Specifically, which particular proposals do you support? Are there any initiatives not included in his plan that you believe should be?

While I support the administrative actions to improve enforcement, I do not believe that they address the most fundamental problem. That is, if state surveyors cannot accurately identify quality of care problems, as we demonstrated in California, changes in enforcement will not improve nursing home quality.

In the current survey process, state surveyors have difficulty determining with certainty whether a facility has quality of care problems, whether quality problems reflect a pattern of care in the facility, and then whether the facility has remedied the quality problems that were identified. Without a more rigorous survey process, stricter enforcement may not bring about the desired effect because quality problems will continue to go undetected and, if detected, surveyors may be less likely to cite the most severe deficiencies. Even making the information available to consumers will be of limited value if the information is misleading.

The only administration proposal directed at improving the state survey process was to increase the sampling for selected kinds of problems such as nutrition and pressure sores. This may or may not make any difference. If the same size sample of residents are reviewed and surveyors merely "look for" these problems in the sample without following stricter review protocols, it will have no effect.

The initiative that I think is most essential to improving quality of care in nursing homes is a more structured survey process for identifying and reporting quality of care problems. While it is not essential to use the precise software and methodology that we used in our study, the five elements that I described in my testimony are all essential. These include: 1) larger samples of at risk populations; 2) review of care for new admissions to nursing homes; 3) collecting uniform quality of care data using a structured protocol; 4) targeting

areas for review based on facility-wide outcomes of care; and 5) use of automation to compare facilities with norms.

3) In addition to enforcement of existing standards, what, if anything, should Congress be doing legislatively to protect patients?

I believe that Congress should mandate that over the next 2-3 years, HCFA and state survey agencies adopt a more structured and scientific survey process with the characteristics that I have outlined above. HCFA should be required and funded to conduct a demonstration of such a system change in several states before implementing it nationally. The approach should then be rolled out to other states. This change in the survey process is far more comprehensive than what is currently being tested in the multi-state demonstration that uses the Minimum Data Set (MDS). The information generated through this revised survey process should be used for surveys, reported to facilities in a usable form, and made available to consumers.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

Washington, D.C. 20201

AUG 7 1998

The Honorable Charles E. Grassley
Chairman
Senate Special Committee on Aging
Dirksen G31
Washington, DC 20510

Dear Mr. Chairman:

As requested, listed below are HCFA's answers for the record to questions from the July 28, 1998 hearing on California nursing home enforcement.

QUESTION: In its final rule for nursing home survey and certification, HCFA stated its enforcement system would encourage "sustained compliance" and would appropriately sanction all deficient providers. Given that mission statement, how could these repeated, serious violations go undetected?

ANSWER: Prior to implementing the new enforcement system and changes to the survey process in 1995, HCFA met with many stakeholders, including industry. All parties expressed a desire to see positive changes that represented more than a stop-gap solution to facility problems. The industry, in particular, suggested that HCFA incorporate the importance of quality improvement and assurance in several key enforcement concepts, such as the plan of correction. The revised concept of "plan of correction" included a new requirement, i.e., that the facility would monitor its performance and ensure maintained correction via quality assurance activities and a functioning facility quality assurance committee. Both the law and regulations encouraged quality improvement and assurance via the operations of a committee within the facility. The consideration of whether a facility was taking initiative in this area and performing the associated self-monitoring and improvement was a factor in applying remedies.

Quality improvement initiatives and quality assurance activities, however, have not been enough to address what continue to be egregious care problems. While HCFA believes that quality improvement initiatives may have some promise, the recently issued Report to Congress found little to no evidence to support a belief in the effectiveness of these initiatives *as they are normally implemented in nursing homes.* As for quality assurance committees, the Report also notes the difficulty in assessing their effectiveness. Some facilities have stepped up internal efforts to improve care; others have not met this challenge. HCFA has concluded that these mechanisms, while having potential value, are not enough and have not adequately served to protect the health and safety of nursing home residents in far too many instances. Hence, HCFA has decided to

more aggressively pursue enforcement actions against providers found to have given poor care or been negligent.

The issue of a failure to detect serious problems relates to shortcomings in several areas, foremost being the inconsistent interpretation of survey and certification principles. While the causes of this variation are debatable, HCFA acknowledges that these findings call for increased Federal oversight of the survey and enforcement system. HCFA is committed to making any modifications and changes needed to clarify policy and provide clear guidance. HCFA is also developing quality indicators that will help identify additional ways to target poor or inadequate care using data and the quality indicators.

QUESTION: The budget request package submitted by HHS includes information showing that current surveys find that 68% of nursing homes fail to meet health and safety requirements and 5% provide substandard quality of care. HCFA also reported that 73% of facilities come into substantial compliance by completion of revisits. With these numbers in mind, what does that say about how California fits into the national average, given that the GAO found 30% of California nursing homes are exposing residents to conditions that are classified as "causing death or serious harm."

ANSWER: The GAO analysis used terminology and classifications that are substantially different from ours. Our data indicate that, according to state survey findings, no more than 6 percent of nursing homes have exposed residents to serious harm, substandard care, or immediate jeopardy of serious harm. If our data are comparable to the GAO's, then nursing home residents in California are at substantially greater risk than nursing home residents elsewhere. However, as our own Report to Congress indicates, there have been serious problems with the survey process, and data based on state survey findings may not reflect the full scope of the problem. We understand that the GAO is expanding its investigation into other states. This expanded GAO investigation should provide a more reliable indication of how California compares to the rest of the country.

QUESTION: In March of 1996, HCFA reported that 85% of all deficiencies cited were at the lower two levels of the scope and severity chart. This means that 15% of the deficiencies found would be in the upper two levels, where enforcement should be stricter. So my question is, for the majority of the deficiencies, those in the lower two levels of the scope and severity chart, how does HCFA monitor to make sure those get addressed?

ANSWER: States perform revisits to ensure that cited deficiencies are corrected in most instances. Several years ago, HCFA issued a policy that stated that if the deficiency did not constitute substandard quality of care and was not at the level of actual harm or above, the State

could consider accepting offsite verification of correction. In instances where the facility also had deficiencies that either constituted immediate jeopardy, had caused harm, or were categorized as substandard quality of care, the State is required to verify correction through an onsite visit.

I hope you find this information helpful. Please contact me if you have questions.

Sincerely,

Michael Hash
Deputy Administrator

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

Washington, D.C. 20201

The Honorable Carol Moseley-Braun
Senate Hart 324
Washington, DC 20510

Dear Senator Moseley-Braun:

As requested, listed below is HCFA's answer for the record to your question from the July 28, 1998 hearing on California nursing home enforcement.

QUESTION: Process for families to make complaints against nursing homes and other involvement in the survey process.

ANSWER: Each nursing home is required to post the phone number of the State survey agency and State Ombudsman where family members and others can call to file complaints. State surveyors follow up on complaints by conducting investigations, and a copy of investigation results are sent to the family member or other person who made the complaint.

Families are involved in the regular survey process, as well. Surveyors are supposed to routinely introduce themselves to family members they encounter throughout the survey process. Families are encouraged to share any information with the survey team about the quality of care and the quality of life their family member is receiving. This dialogue is informal, ongoing and varies in intensity depending on the issues being investigated. Formal interviews are conducted with family members of selected residents who are cognitively impaired and cannot speak for themselves.

I hope you find this information helpful. Please contact me if you have any questions.

Sincerely,

Michael Hash
Deputy Administrator

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

Washington, D.C. 20201

AUG 7 1998

MEMORANDUM

TO: Senator Charles E. Grassley
Senate Special Committee on Aging

FROM: Michael Hash
Deputy Administrator, Health Care Financing Administration

RE: HCFA Nursing Home Enforcement Timeline

Enclosed please find HCFA's Nursing Home Enforcement Initiatives and Target Completion Dates per your request. We will notify you with any significant changes in our plans. Please contact me if you have questions regarding the timeline.

Enclosure

HCFA NURSING HOME ENFORCEMENT INITIATIVES AND TARGET COMPLETION DATES
August 7, 1998

August 1998

- Meet with senior regional office officials to discuss initiatives and plan regional activities supporting initiatives
- Meet with national organizations to discuss initiatives, including the definition of "poor performing facility" (GAO)
- Clarify HCFA's revisit policy via letter to ROs and State agency Directors (GAO)

September 1998

- Put most recent survey results for all nursing homes on the Internet
- Meet with stakeholders to begin planning abuse intervention campaign
- Refine list and methodology for choosing worst nursing homes
- ROs begin using new Federal Monitoring System
- Meet with DOJ and IG to develop an interagency plan for appropriate identification, referral, investigation, and where necessary, prosecution of egregious violations

October 1998

- Begin enhanced monitoring of the worst nursing homes
- Present and get feedback from stakeholders on plan for national consumer information campaign on abuse prevention
- Communicate to ROs the process of referring egregious violations (false claims) to DOJ

November 1998

- Finalize enhanced guidance/protocols for using effective drugs
- Present and get feedback from stakeholders on plan for national consumer information campaign on prevention of malnutrition and dehydration

December 1998

- Finalize Internet plans for the repository of best practice guidelines for caring for residents at risk of weight loss and dehydration
- Publish manual instructions to conduct random surveys in nursing homes (GAO)
- Publish final regulations to propose a civil money penalty for "each instance"

January 1999

- Begin phase-in of consumer information campaign on abuse prevention
- Begin phase-in of consumer information campaign on prevention of malnutrition and dehydration
- Publish manual instructions regarding criteria for Federal sanctions for inadequate State survey performance

February 1999

- Finalize definition of "poor performing nursing home chain"
- Publish enhanced guidance/protocols on key quality of life/quality of care issues

March 1999

- Monitor implementation

April 1999

- Begin using the new definition of "poor performing facility" to determine if remedies will be imposed immediately (GAO)
- Increase the survey sample size for nutrition, dehydration & pressure sores (will be phased in) (GAO)
- Develop protocol for checking facility's abuse intervention system (will be phased in)

May 1999 - forward

- Monitor implementation, assess effectiveness, and make necessary revisions

Congressional Action Required:

- Publish regulations to implement legislation requiring facilities to perform criminal background checks
- Publish regulations to implement legislation to increase staff permitted to feed residents

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

AUG 5 1998

The Honorable Fob James, Jr.
Governor of Alabama
Montgomery, AL 36130

Dear Governor James:

I am pleased to take this opportunity to share with you a Fact Sheet outlining the Department of Health and Human Services' initiative to continue improving the quality of care Medicare and Medicaid beneficiaries receive in nursing homes.

In recent years, we have made major strides in improving our survey and enforcement procedures for nursing homes. However, we recognize that we must do more to improve the quality of care our beneficiaries receive when they enter a nursing home, and a report to Congress that we released recently underscores this need. As part of our new initiative, we will work with States to improve their nursing home inspection systems; crack down on nursing homes that repeatedly violate safety rules; require nursing homes to conduct criminal background checks on all new employees; reduce the incidence of bed sores, dehydration, and malnutrition; and publish nursing home quality ratings on the Internet. We take this responsibility very seriously, and I know you do as well.

We are committed to making changes to the survey and enforcement process, but that alone will not make the difference. I believe that we, the Federal government and States, must work together with nursing homes and others toward the common goal of providing the highest quality care to every resident in a nursing home. We want your support, and we want to work with you.

I hope you find the enclosed Fact Sheet informative. I look forward to working with you as we continue to improve the quality of care residents receive in America's nursing homes.

Sincerely,

Donna E. Shalala

Enclosure

QUESTIONS FOR SHELDON GOLDBERG
Senate Aging Committee Hearing on Nursing Home Care
on July 28-29, 1998

Question #1 - Enforcement: "...Don't you agree that swift and certain penalties for nursing homes with first- and second-time offenses could help prevent further deficiencies down the road? Shouldn't we provide an incentive at the outset for nursing homes to be in compliance?"

AAHSA continues to support strong enforcement action for nursing facilities with a history of chronic and/or repeat noncompliance. We also believe that there can be instances where a single act of noncompliance may be so egregious that immediate imposition of a remedy or remedies is certainly warranted.

However, calling for an enforcement process with "...swift and certain penalties for nursing homes with first and second time offenses" to some extent ignores the sanctions that already are available for these kinds of offenses under current regulations. The current regulatory system recognizes an extremely wide and varied spectrum of potential violations - from the very minor to the very serious - and provides for a correspondingly varied array of sanctions that states may impose. Calling for immediate and stringent sanctions for first offenses, without any reference to the seriousness of the violation, could easily lead to a system that would be inappropriately punitive and that would prove to be administratively and financially overburdensome to States, the Federal government, and to facilities in terms of the additional dollars that will be expended in the form of extended surveys, resurveys, and appeals of erroneously cited deficiencies.

Current law allows for the imposition of immediate penalties for violations of nursing home standards for serious violations, and as explained below, for continued violations that are not corrected. Testimony given during the Special Committee on Aging's hearing charged that nursing facilities that failed to correct violations were able to avoid paying any penalty. If that is the case, it is the state's failure to impose penalties that are available under existing regulations that is to blame; new laws and regulations are not needed.

Background

Prior to OBRA '87, under Federal law the only adverse actions available to HCFA and the States were termination, non-renewal or cancellation of provider agreements, denial of participation in the Medicare/Medicaid programs, and denial of payment for new admissions. The latter was considered an "alternative" remedy at that time because it was an alternative to termination. OBRA '87 amended the law to incorporate and

expand the range of remedies that could be imposed in lieu of termination. These provisions recognize that all noncompliance is not equal, and that particularly in the case of lesser violations, sustained compliance can be promoted through the imposition of appropriate and remedial actions rather than through a single or "blanket" remedy, imposed regardless of the type and degree of noncompliance.

In the November 10, 1994 Final Rule; Survey, Certification, and Enforcement of Skilled Nursing Facilities and Nursing Facilities, in keeping with the law, HCFA stated its intent to implement an enforcement process that would base "...selection of a particular remedy [or remedies] on the nature of the deficiency [or deficiencies], and on the determination by HCFA or the Medicaid State agency that the remedy [or remedies] selected are the most likely to achieve correction of the deficiencies..." HCFA further expressed its belief that "...remedies applied in this manner would serve to both deter violations and encourage immediate response and sustained compliance..." AAHSA concurs with these concepts as the premise for the enforcement process. Even a civil money penalty should be remedial in the sense that it serves as the best means of assuring correction and sustained compliance.

Opportunity to Correct

In its report, the GAO refers to "amnesty" afforded to facilities under federal law once deficiencies are corrected, in the form of "forgiving" the noncompliance once correction is achieved. "Amnesty" is an inaccurate characterization of this process.

It is true that under current law facilities with a good compliance history are given the opportunity to correct deficiencies within a given timeframe and defer imposition of a recommended sanction. A good compliance history is defined as no determinations of substandard quality of care within the current or previous two surveys. It must be very clear, however, that deferral of a sanction does NOT negate or remove the deficiency citation. Failure to correct the violation results in imposition of the remedy. A repeat violation in this same or a related area on any subsequent survey will result in incrementally more severe civil monetary penalties and/or other available alternative remedies. This is not "amnesty" or "forgiveness" of the deficient practice or of the violation itself.

This deferral of a remedy is consistent with the intent of the law—to promote and support sustained compliance—rather than simply punishing facilities found to have a deficient care practice. This purpose is also consistent with the goals and recommendations set out in the Institute of Medicine (IOM) Study, *Improving the Quality of Care in Nursing Homes*. The study emphasized the need for sustained compliance and concluded that enforcement procedures should "be less tolerant of substandard homes that are chronic or repeat violators"; and that the system should "take historical offenses into account as well as the most recent survey findings in applying sanctions to solve the problem of the chronically substandard facility." The IOM study defined a

repeat violation as "any major violation of a standard under a resident-care-related condition of participation if any other standard under the same condition was found out of compliance on the previous visit, " and stated that "Any conditions that deal directly with the health and safety of residents should be included in this definition."

There are federal criteria for identifying those homes which do have a history of chronic or repeated noncompliance or which have provided substandard care as "poor performing facilities." The HCFA State Operations Manual (SOM) #273 describes Poor Performing Facilities as those facilities with "a history of going in and out of compliance and/or a facility that has no system in place to monitor its own compliance." The concept of "poor performers" therefore serves to create a distinction between those facilities with a history of chronic and/or repeated noncompliance, and those that have remained in compliance or have experienced noncompliance on a given survey, but have demonstrated a general ability to identify problems, correct deficiencies, and achieve and sustain compliance. These facilities do NOT have the "opportunity to correct" and are subject to the imposition of sanctions regardless of how quickly they come back into compliance. Under the law, failure to come into compliance within six months under any circumstance results in automatic termination from the Medicare and Medicaid programs.

Consistent with the IOM study, both OBRA '87 and the final regulations require the imposition of more severe penalties for repeat violations. This process exemplifies the tools the system has available to respond to chronic or egregious noncompliance through the imposition of remedies in accordance with the scope and severity of the noncompliance. To strengthen enforcement, it is not necessary to legislate new penalties or issue new regulations; it is the process of applying existing regulations that needs to be improved.

Incentives and Regulatory Improvements

OBRA '87 mandates that all nursing facilities be surveyed on an annual cycle ranging from nine to fifteen months, with an average of twelve months. Surveys are an extremely time-consuming process for both nursing facilities and for the state surveyors, as they should be. Since all facilities must be surveyed within the confines of this timeframe, surveyors do not have the opportunity to focus their time and resources on the problem facilities that need more attention. Surveyors must spend as much time in facilities with a consistently deficiency-free record as they spend in facilities where the quality of care has been consistently poor.

The nine- to fifteen-month range that OBRA '87 provided for survey cycles indicates a congressional intent to give surveyors some flexibility to inspect nursing facilities with differing frequency. AAHSA feels that the oversight process would be made much more effective if this flexibility were expanded to enable surveyors to inspect facilities with good records at intervals of up to two years. This expanded survey cycle would give surveyors the true flexibility they need to concentrate their time and attention on

the facilities with records of poor care so that bad conditions are corrected and consistently bad facilities are shut down.

Recommendations
First, we repeat our suggestion that surveyors be given the flexibility to extend the survey cycle for 24 months for good homes so that they can focus on rehabilitating or closing chronically bad facilities.

- Our second recommendation is that government agencies start paying more attention to which facilities are initially licensed by the state and then certified for participation in Medicare and Medicaid. There is no reason to believe that multi-facility providers who give poor care in another state, or in another part of the same state, will give stellar care in a different facility.

- When addressing the efficacy of sanctions under the long-term care survey and enforcement process, there has long been a tendency on the part of the Administration [and consumer advocates] to focus only on the use and amounts of civil money penalties. OBRA '87 afforded the States and Federal Government a broad range of remedies with a goal of promoting compliance through use of the most appropriate remedy. AAHSA strongly recommends a study of the use and efficacy of these other, alternative remedies. Again, rather than calling for new or additional regulations, the committee should determine whether the states are making the best or most effective use of the ones we already have.

Conclusion
We take the GAO report seriously -- everyone should. We note, however, that the GAO qualified its observations by stating that they could not be used to draw adverse conclusions about all nursing homes. GAO is correct. But just as the report cannot be used to condemn all nursing homes, it cannot be used as a blanket indictment of all state survey agencies. To do so sets up the following scenario:

- The only evidence that surveyors are doing their job is to cite high numbers of deficiencies and collect large fines;

- Therefore, if the homes are good, the surveyors must be bad;

- If the homes are bad, then the surveyors must be good.

The scenario says that it is impossible to have good homes and good surveyors in the same state. This may be the single most counterproductive result of the report and subsequently, the hearing. Think of the consequences:

- Good homes unjustly accused of bad care cannot sit still and take it on the chin.

- If they accept unjust findings, they are eventually disgraced and may even be excluded from Medicare and Medicaid

- Good homes MUST contest unwarranted citations

THE END RESULT: the surveyors will be in court rather than in the bad homes.

This wastes just as much time as forcing the surveyors to spend excessive amount of time in good homes to begin with.

We recognize that there still are nursing homes that do not provide good care. To say, however, that small numbers of deficiency citations within a state indicate a lax survey process is to deny the progress that has been made in improving the quality of care in most nursing homes. Several independent studies have verified that almost two decades of effort by Congress, federal and state agencies, consumer advocates, and the providers themselves have resulted in a vastly decreased use of physical and chemical restraints, better maintenance of residents' ability to perform activities of daily living, and other improvements in care. We believe that declining numbers of deficiency citations for the most part mean that all of the laws, regulations, and private quality initiatives have been primarily a success, and that the quality of care in the vast majority of nursing facilities is far better than it was two decades ago.

Question #2 - Staffing Ratios: "What kind of staff-to-patient ratio do you consider appropriate? If you oppose legislation or regulations that set minimum staffing levels, how do you suggest we encourage nursing homes to follow recommendations to increase staffing levels?"

The nursing home quality reform provisions of the Omnibus Budget Reconciliation Act of 1987 (OBRA '87) enacted the most sweeping changes to nursing facility operations since the passage of Medicare and Medicaid. One of the most significant transformations resulting from the passage of OBRA '87 was the shift in focus of regulatory oversight from facilities' capacity to provide care, "paper compliance" with requirements, to one on resident outcomes, that is, the actual care provided.

In keeping with the statutory intent to focus on outcomes rather than process, the current Requirements for Participation for Long Term Care Facilities, promulgated as a result of OBRA '87, require that facilities have "sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident..."

Both the provider and consumer communities have long supported the shift from process to outcomes as a means of assessing quality of care. Any attempt to assure the provision of optimal care based on mandated nurse staffing ratios would defeat all of the efforts that have been made within both the legislative and regulatory arenas to achieve this goal. Additionally, any assumptions of quality based on numbers of nursing staff and nursing hours rather than on efficient use of nursing staff and resident outcomes is simplistic and potentially deceptive.

Outcomes vs. Ratios

Establishing mandated staffing ratios may seem an obvious and even easy solution to care problems resulting from inadequate staffing levels. However, upon closer examination it becomes clear that this is a response that is fraught with potential problems for consumers and providers, as well as regulatory authorities.

First, while too little staffing is certainly likely to lead to poor outcomes, there has never been any proven correlation between higher staffing levels and the guarantee of positive outcomes.

Second, when considering mandated ratios, it is critical to remain aware that standards are, by their very nature, minimum. Inherent in any mandate for staffing ratios is the very real danger that the minimum will become the maximum - a scenario that becomes even more likely within the current environments of managed care, Medicare prospective payment, and the accompanying climate(s) of reduced payment and cost containment. These are all serious considerations. However, there are additional ramifications of translating ratios into quality that may prove even more disturbing.

An oversight system that is driven by a "care-by-numbers" formula is diametrically opposed to the outcomes-based process to which we have all long aspired. Beyond that, such a system can also result in a "regulatory box" that is, in fact, counter-productive to improving quality of care. Codifying ratios of staff to residents would mean that "inadequate staff" could no longer be considered a contributing factor to care deficiencies and it would become indefensible as a citation in the face of poor care. As long as facilities met the required staff "numbers" for the populations they are serving, there would be no justification for the survey system to look to insufficient staff as a possible cause of poor resident outcomes.

Another issue that must be explored is the differing standards that different offices of HCFA apply to nursing facilities. On the quality side, surveyors would want to see maximum numbers of staff. The Office of the Inspector General, however, would be constantly questioning whether such staffing levels were "medically necessary", or whether staffing was excessive enough to constitute waste and fraud against the Medicare program. We already are seeing cases in which therapies and other services that facilities have provided pursuant to OBRA 87 have been held not medically necessary by the OIG. Under a numbers-only based system, the consequence of a facility's decision to opt for increased staffing could be allegations of fraud and abuse emanating from an Inspector's General's determination that it is providing unnecessary services. This is a very real issue for not-for-profit facilities that have traditionally staffed at higher levels.

One possible alternative to a straight staffing ratio would be to create a "grid" of staffing requirements based on the case mix of a facility's population. However, this would likely prove to be an extremely complex, ever-moving, and potentially costly methodology in light of the rapid changes that are occurring in both the types of care and services provided and the acuity levels of nursing home residents. In addition to hospice, respite care, and shorter-stay post-acute patients with intense nursing and rehabilitation needs there are the "long-term", long-term care residents. These are the historical nursing facility populations, comprised largely of very frail, chronically ill, elderly individuals with broadly varying needs and intensities of care. Because of age and frailty, many have limited potential, diminished responsiveness to treatment, and a decreased tolerance of certain treatment modalities such as drug therapies. Care and services decisions are further complicated by the frequent occurrence of ongoing multiple conditions for which these individuals are simultaneously being treated and by the numbers of residents with cognitive impairment - estimated to be more than 70%. Nursing facilities now serve a much more varied population than they did even ten years ago, and we do not see how a static staffing ratio would take all of these varying needs into account and ensure that they were met.

Finally, there is one more potential consequence that must be considered -- a mandate for nurse staffing ratios discounts the growing role of technology in nursing facilities. One example that can be cited from the past is the Hoyer Lift. Prior to its implementation, two nurses or nurse aides would be needed to lift one resident. With

the lift, this task can be performed by one nurse or aide, cutting the number of required staff by half. Having to recalculate staffing ratios every time a new mode of technology is developed that can substitute for, and possibly perform better than, human intervention would be burdensome and overly bureaucratic.

Nurse Aide Shortage

AAHSA firmly believes that mandated staffing patterns numbers are contrary to an outcomes-based assessment of care. However, we do not dismiss the argument that a poor resident outcomes can result from a shortage of staff, particularly nurse aides. Both the GAO report and the testimony heard at the hearing suggest that inadequate staffing of nurse aides may have contributed to some of the problems cited.

We acknowledge that one of the key challenges faced by nursing facilities is the ongoing shortage of nurse aides - a shortage that has been exacerbated in recent years by the downsizing of professional staff and increased use of paraprofessionals in acute care, as well as the growth in demand for aides in home health care. Because of the competency evaluation and certification associated with the Nurse Aid Training and Competency Evaluation Program [NATCEP] for nursing homes, it has become increasingly attractive for providers from other care settings to recruit and hire nurse aides trained and certified under these requirements. The benefits reaped from hiring nursing facility aides are particularly evident to acute care facilities, which are not currently operating under any similar mandate to provide training to their aides.

While nursing facilities have been working to enhance the functions of the nurse aide, including greater development of career ladders, home health agencies and hospitals are frequently able to offer greater flexibility in scheduling and/or higher wages. The result is that aides are being trained and certified in nursing facilities, and then moving on to apply their skills in other settings. Thus, while higher acuity levels among nursing facility residents, as well as projected aging demographics, point to a demand for paraprofessional staff in nursing facilities that will continue to escalate, nursing facilities find themselves in the untenable position of seeking to fill these positions from an already limited labor pool that is currently being drained by acute and home care providers. Given the status of state and federal payments to nursing homes, our ability to compete with hospitals and home health agencies is minimal. The irony, of course, is that long-term care--arguably the most poorly-funded component of the health system--is actually subsidizing those providers which are not required to bear the cost of training their personnel, as are we.

Specialized Training

AAHSA has proactively worked to alleviate the shortage of nurse aides and has developed a proposal to respond to this issue under some limited circumstances. As stated above, nurse aides are subject to mandated training requirements and competency evaluation. In the nursing home environment, many employees who are neither nurse aides nor licensed health professionals also have frequent and regular contact with residents, either by personal choice or as an integral part of their job.

Permitting these individuals to perform tasks determined to be non-nursing-related may offer some relief to the nurse aide shortage without compromising the health and well-being of the resident.

Three areas of potential non-nursing employee assistance have been identified. Assistance with eating is probably the most frequently cited, but others include transporting and mobility, and activities.

Allowing non-nursing employees to provide assistance would be based on the needs and potential risks to the individual, as identified in the comprehensive assessment and determined by the licensed nurse responsible for the resident. For example, assisting a resident with a swallowing problem to eat would be considered nursing-related, while helping an alert and competent resident with a paralyzed or immobilized arm would not. Personnel performing non-nursing-related tasks would be required to complete relevant in-service training approved by the regulatory authority and demonstrate competence in the duties assigned.

AAHSA has developed legislative language to permit delegation of non-nursing tasks. A copy of our proposal is attached.

Nursing Education

Traditionally, nursing students have received little training geared specifically toward the care of geriatric patients. AAHSA has long supported efforts to increase academic awareness and opportunities for nursing experience in long term care settings. We have emphasized that nursing education and training must be designed to include care of the very frail and elderly as an integral component of the curriculum.

AAHSA has encouraged our nursing home members to open their doors to nursing schools and to offer opportunities for rotation through their facilities. We have also supported the concept of career ladders for nurse aides to enter the field of professional nursing. Since 1989 the Association has, under a grant from the Patient Care Division of Proctor and Gamble, sponsored an annual scholarship program for nurse assistants to become RNs or LPNs. In addition, we have many nursing facility members who have independently developed scholarship or tuition assistance programs to enable nurse aides under their employ to become registered (RNs) or licensed practical nurses (LPNs).

AAHSA believes that further demonstrations at the federal level should create opportunities for exposure and entry of nurses into the field of long term care. Such actions could include the initiation of long term care nursing demonstration projects under the auspices of the Public Health Service, Bureau of Health Professions, Nursing Division, to support the development of innovative curriculum for nursing students that would include rotation through facilities. Another recommendation would be that the Federal government earmark loans with forgiveness programs for nurses who enter long term care as a field of practice. Such projects would serve to increase awareness

of the long term care nursing experience for both individuals and educational institutions, motivate entry into nursing facility care as a field of practice, and ultimately enhance the quality of care being provided to the residents of these facilities.

Reimbursement

Reimbursement rates and policies for nursing facilities must also be considered in addressing the adequacy of nurse staffing. A 1988 report by the Commission on Nursing of the Department of Health and Human Services found that on average, registered nurses in nursing facilities earned 35 percent less than their hospital counterparts. Similar salary differentials existed for licensed practical nurses, nurse aides, and other nursing personnel in the same area. Such disparities in salary levels for long term care nursing staff are due, in large part, to inadequate Medicaid reimbursement rates and the Medicare cost limits that establish and restrict the amounts that can be reimbursed for the costs of nursing care.

Since as much as 70 percent of the cost of nursing facility care is attributable to staffing, such limits on reimbursable expenses continue to have a chilling effect on salaries. Nursing facilities are unable to offer wages competitive with other health care settings.

Federal policy should assume more responsibility for assuring that State Medicaid programs be required to provide adequate payment for all costs of care to Medicaid residents, including nursing care. Consideration should also be given to adjusting Medicare reimbursement rates to allow for higher staff salaries..

Conclusion

The OBRA '87 nursing facility reform amendments were primarily designed to ensure the provision of quality care to the chronically ill, elderly "long-stay" resident. While the need to assure optimal care to these residents certainly remains, the years since the passage of OBRA '87 have seen significant changes in the residents and operations of many nursing facilities. In addition to the growth in development of such special care units as those for residents with Alzheimer's Disease and related dementias, the rise of a new "constituency" for nursing home providers has occurred. These are individuals who are patients, not residents, who are younger, and who are admitted for short-stay or transitional services such as postacute or subacute care, intensive rehabilitation services, hospice, and respite care.

The need to effectively respond to the varying intensity of care required by these patients and residents through different levels of staffing is evident. The ongoing ability for facilities to determine staffing ratios based on acuity levels and case mix will become even more pronounced as these changing populations continue to increase. The establishment of minimum staffing levels in the present environment is likely to result in maximums that will be insufficient in years to come. Additionally, since best practices for these different specializations are just emerging, particularly for the care of

Alzheimer's residents, the dictating of any type of model staffing level at this point in time would be extremely premature.

In light of all of the above, it becomes impossible to conclude that dictating staffing levels through sheer numbers can provide an adequate solution. The other and certainly more preferable alternative would be to continue in the direction - and to commit the resources necessary - to establish a survey and enforcement process that is truly outcome-based. The computerization of the long-term care standardized resident assessment process (RAI/MDS) certainly offers one of the key tools necessary to monitor individual progress and decline as well as facility patterns and systems for care. The OBRA mandate that facilities ensure that each resident achieves his/her "highest practicable physical, mental and psychosocial well-being" provides the means under the law to enforce the attainment of these outcomes.

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August 21, 1998

The Honorable Charles E. Grassley, Chairman
Senate Special Committee on Aging
G-31 Dirksen Senate Office Building
Washington, D.C. 20510
Attn: Emilia DiSanto

Dear Senator Grassley:

Enclosed please find responses to the additional questions submitted by you in conjunction with your July 27th & 28th hearing on nursing home quality in California.

We believe this hearing could have a productive effect on the quality of care in our nation's nursing facilities, and on the effectiveness of our extensive system of state and federal government oversight. The extent to which positive progress will be made will of course depend upon whether all parties can come together to make policy improvements in a thoughtful manner with the care of our residents foremost in mind.

We thank you once again for your foresight in holding this hearing, and look forward to working closely with you and the committee as we strive together to improve the environment for caregiving in California and nationwide.

Sincerely yours,

Paul R. Willging, Ph.D.
President

The American Health Care Association is a federation of 50 affiliated associations, representing 11,000 non-profit and for-profit nursing facility, residential care and subacute providers nationally.

1). **Senators Reid, Grassley & Kohl are waiting to pass legislation that would establish a national registry of abusive workers and require criminal background checks for nursing home employees. While I realize that this is one part of a larger problem of nursing home safety, what benefits do you see in passing such legislation?**

A: The American Health Care Association has been working with Congress and our nation's Attorneys General for many years to create and implement such a system. The frail and vulnerable citizens who rely on caregivers for their daily needs should be protected from those who might take advantage of them; regardless of the care setting.

The benefits would be to provide an additional layer of protection against abusive caregivers at both the state and federal levels. Currently, persons with a history of abuse need only to use an alias and cross state borders to gain the opportunity to take advantage of the residents we try so hard to protect. If such a system prevents even one abuser from entering our homes, it is worthwhile, and a national database with prompt identification capacity would catch many.

It bears noting however that a system in which the results of a check are not returned for several-months or more could do more harm than good. It could give facilities and residents a false sense of security while creating a window in which those who seek to do harm are allowed to enter our doors.

Lastly, it is important to note that the cost of such checks (which we estimate could exceed $15,000 per facility each year) unless passed through to Medicare and Medicaid, would sap funds that would otherwise be used to provide patient care.

2). **The nursing home industry suggests that a system of cooperation works better than strict enforcement. The Congress is also aware that your industry believes that those nursing homes with a history of egregious deficiencies should be penalized and even put out of business. However, don't you also agree that swift and certain penalties for nursing homes with first and second time offenses could help prevent further deficiencies down the road? Shouldn't we provide an incentive at the outset for nursing homes to be in compliance?**

A: In the vast majority of facilities, deficiencies are not the result of unwillingness, but lack of adequate information and tools to measure, define, communicate, and correct the problems. Harsher penalties and more government regulation will do nothing to help these facilities improve care. HCFA is currently attempting to come up with a system to label facilities as "poor performing" and to issue immediate "penalties" for those citations. As the government seeks to label facilities as "poor" it is critical that the definition not be driven by desire to attain a preordained percentage of facilities. It is also critical that good performers with isolated deficiencies with no actual harm not be labeled as "poor". We believe the methodology they are preparing would do exactly that.

If we had a survey system which was reliable, consistent, or which was a measure of outcomes rather than process, stiff penalties and fines for first time violations might be a good incentive to keep quality high. But by HCFA's own admission, the current system does not measure quality of care. Instead, this system focuses on compliance with process-based requirements rather than resident outcomes. The top four most-often cited deficiencies are process requirements with little impact on resident care. Adding to the difficulty is the fact that the survey system is subjective and often capricious. This type of enforcement is as likely to find technical deficiencies in a home providing the best care as to miss real care problems in poor performing homes. Without consistency and predictability as to what will be decided is a violation, there can be no "incentive" provided through swift penalties.

The focus of recent efforts to tighten the system of enforcement has been on issuance of "penalties." It is important to note that OBRA'87 and subsequent HCFA Enforcement regulations were specifically intended to provide "correction" - - not "punishment" for facilities cited with non-harm deficiencies.

As to the latter part of this question asking "whether we should provide incentives at the outset for homes to be in compliance", our answer is a resounding "Yes". However, I believe a more attractive incentive than fines would be such actions as less frequent surveys for those homes in complete compliance, more residents, higher reimbursement rates or public recognition for excellent facilities. These are motivational factors which would truly provide incentives for facilities to strive for excellence.

3). **Much of the testimony during the hearing focused on staffing levels. In addition, recent research points to inadequate staffing as a major contributor to poor care. What kind of staff to patient ratio do you consider appropriate? If you oppose legislation or regulations that set minimum staffing levels, how do you suggest we encourage nursing homes to follow recommendations to increase staffing levels?**

A: Caring, informed, and well-trained staff is the most critical ingredient of long term care in any setting. It is easy then to oversimplify this fact and to set one ratio which leads people to believe that as long as a facility meets this number, care in that facility will be good. Unfortunately those with experience in long term care know that this is not the panacea it is proported to be.

There does not exist one appropriate staffing level for ALL facilities, but there is an appropriate staffing level for EACH facility. It depends on the acuity of the residents, the level of skilled personnel, the communication and coordination between personnel and shifts, and many other factors. As a facility takes in new residents, its staffing needs will change.

Staffing is also the highest cost of providing nursing facility services. Unfortunately, unlike most businesses, if the cost of labor goes up, nursing facilities can not simply raise the price of goods or services. Since nursing homes are dependent upon the state and federally set rates for over 75% of their residents, and only 3% have private insurance, our providers have almost no ability to pass on higher costs to the consumer. Therefore, any increase in labor costs must be offset elsewhere; be it the supplies, services, or operations. This is the "catch-22" under which nursing homes operate every day.

It is because of this reality that the staffing levels which currently exist in our nation's nursing facilities are the levels deemed appropriate by the policymakers who set the rates at the state and federal levels. Repeal of the requirement that nursing facility payments be **"reasonable and adequate" to meet costs** sends a strong signal as to the priority of nursing facility staffing and quality in the face of actually paying for them

AHCA does not oppose appropriate staffing levels and in fact has been pushing for a system by which acuity levels, staffing levels, and appropriate reimbursement, can be tied together with consideration given to other factors which impact the care needs of our residents.

CALIFORNIA
ASSOCIATION OF
HEALTH FACILITIES

CAHF

*Supporting People,
Health and
Quality of Life*

August 4, 1998

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The Honorable Charles E. Grassley
Chairman
Special Committee on Aging
United States Senate
Washington, DC 20515

Dear Senator Grassley:

We appreciated the opportunity to review a preliminary draft copy of the GAO Report entitled "California Nursing Homes, Care Problems Persist Despite Federal and State Oversight," and were pleased to see that some of the inaccuracies in the draft were corrected in the final report. Serious problems remain with the report and our concerns are detailed in the attachment to this letter. It is a major concern to us, as well as to you we believe, to not have public policy be based on poor information provided to you and your Committee. We are equally concerned that policy not be based on unfounded anecdotes.

While we strongly disagree with the tone set for the recent hearing, the treatment of some witnesses, and the quality of the base report, we are generally supportive of the recommendations from the GAO. We do have questions with the appropriateness of mandated follow up surveys as an effective use of funds available to the survey process.

The process for determining and enforcing compliance and therefore attempting to ensure some measure of quality of care has not changed materially since the inception of the Medicare and Medicaid programs. Previous studies done by Abt Associates have repeatedly found the current system lacking. We agree. Tinkering with the current process will never achieve the goals that consumers, providers, and payers all want and deserve. We were therefore, very disappointed that the Report did not recommend that new and innovative methods of ensuring quality care be studied through the utilization of pilot projects.

There appears to be an unwillingness on the part of both the GAO and HCFA to look at alternatives to the current system; alternatives that would perhaps be less bureaucratic but possibly more effective!· For HCFA to believe that their current system is the best and only quality evaluation system is absurd. HCFA's approach to the work done by Abt Associates in the recent 900 page release reflects their commitment to stay with the current system when we all know it really does not work.

There are more than 100,000 people working very hard in California to provide long term care services to some very ill people. Accidents do happen as all care providers are human. We do everything we can to prevent this through pre employment screening, training at double the federal standard, and through mandated minimum staffing ratios. We need to focus on and reward those providers who consistently provide exemplary services, while at the same time using the tools that government survey agencies currently have to put chronically bad operators out of business.

We hope to work with you to this end.

Sincerely,

GARY D. MACOMBER
Executive Vice President

RESPONSE TO GAO REPORT
CALIFORNIA NURSING HOMES, CARE PROBLEMS PERSIST DESPITE
FEDERAL AND STATE OVERSIGHT

The California Association of Health Facilities (CAHF) is a non-profit, professional organization dedicated to improving health care. CAHF's membership is comprised of more than 1,450 licensed long term care facilities serving a wide spectrum of health needs in setting which include: skilled nursing, intermediate, subacute, mental health, rehabilitation and residential; along with providers of services for persons with developmental disabilities. Nearly 100,000 trained medical, professional and support service staff care for 200,000 Californians residing in these member facilities each year. CAHF is affiliated with the Quality Care Health Foundation, the Council of Long Term Care Nurses of California and the American Health Care Association.

Abuse and neglect of the patients in nursing homes can not be tolerated, however, a rational and reasoned approach to real solutions is needed. Studies with serious methodological design flaws which cause inflammatory media coverage and exploitation of providers does little to provide for these solutions.

Study Methodology

We take issue with the fact that a study on death certificates of patients who died in 1993 is being used to determine whether or not there are care problems in 1998 -- five years later. It was during this time period that California fully implemented the new HCFA enforcement requirements and was, for some years, considered an outlier because of the number of remedies (sanctions) imposed against providers. Conclusions about care and/or the enforcement system can not be drawn from the study of death certificates, much less those that are five years old.

Nor can results be drawn from two onsite surveys. In a state which has over 1450 facilities, this is not even remotely close to a valid sample. The utilization of the federal and state data bases, OSCAR, ODIE and ACLAIMS does little to increase the validity of the conclusions reached. The report states that the OSCAR system, because of the exclusion of certain data, may understate the deficiencies, yet makes no mention of the fact that corrections to both the OSCAR and ACLAIMS systems are rarely made when providers have successfully appealed deficiencies and/or citations and asked that they be taken off their records. In addition, the study did not look at appeal results. This means the data must currently be overstated.

The process to review patient records utilized "practice guidelines." We are unable to determine from the report what practice guidelines were utilized. Long term care practitioners have not been adequately represented in the development of practice guidelines such as those developed by AHCPR. The development of long term care practice standards has taken place generally in a

setting which is not representative of the delivery system. Guidelines are based on acute care models in which direct care givers and funding differ. The cost containment policies of the Medicaid programs which funds the majority of nursing home care do not allow for some of the practices described in these guidelines. In addition, the guidelines are very straight forward and do not address the complex care considerations that are needed for the care of an aged patient. For these reasons practice guidelines, which do not consider these issues, are generally unfair standards against which to measure care. Wide disparities between acceptable standards of practice and funding to meet those standards only delude the public.

The GAO review team did three onsite survey visits. This small sampling in such a large population (1450 facilities) can hardly be considered valid in order to draw the conclusions that care issues were not identified on surveys. Although the study cites other studies to support its findings, this does not make up for the lack of a valid sampling. In addition, the utilization of the data from the federal OSCAR and state ACLAIMS systems as evidence to support the conclusion that sustained compliance is not being attained by the survey process is questionable. The report is very biased in that it only cites examples of deficiencies which support its conclusions. There are no examples of deficiencies that have been appealed and overturned. There is no indication of how the examples were selected.

In addition, the method for concluding that there were 407 deficient facilities is questionable. It uses a time period, 1995-1998, which abnormally inflates the number. The Association's data base which also utilizes the OSCAR and ACLAIMS systems shows that of the 1330 surveys in the system for 1996 only 8.5 percent were cited for substandard care and of the 1297 surveys in the system for 1997 only 6.4 percent were cited for substandard care. This obviously gives a very different perception. From a reading of the report and the methodology, one can not determine if the mixing of state citation data with survey data also contributed to an unfairly inflated number of 30 percent of the facilities causing death or serious harm. For example, many of the state citations are based on survey findings, so one incident can generate two sanctions, a survey deficiency and a state citation. If this was not considered, then again the numbers become inappropriately inflated. To portray a picture, as the graph on page 9 does, that 30 percent of the facilities in California have violations which caused death or serious harm is a serious misrepresentation of the truth.

The study cites rates of pressure ulcers, incontinence and malnutrition as evidence of poor quality of care. This is a very superficial analysis. Dr. David Zimmerman, who developed some of these indicators, has repeatedly stated that these care needs are only indicators that problems may exist and are not to be used as measurements of quality of care. The report does not provide the answers to the questions raised by the indicators such as: were patients admitted with these problems?; were ulcers decreased in size after admission?; how many ulcers actually developed in the nursing home?; and, was there medical justification that the ulcer was avoidable or unavoidable?

As the survey and enforcement of Medicare and Medicaid requirements in nursing homes becomes more data driven, we are concerned that data will be inappropriately used by researchers to reach unsubstantiated conclusions. Of particular concern is that in the nursing home setting, unlike other health care delivery systems, "quality indicators" are negative outcomes. This puts providers at much higher risk if the indicators are inappropriately used as measurements based on investigative

studies which are less than comprehensive.

Focused Enforcement

As an association, we are supportive of focused enforcement in a fair and consistent manner on the minority of providers who egregiously continue to provide poor quality of care. It is this segment of the delivery system which continues to drive the public's image and governmental legislation and policies. Quality providers should no longer be hampered by "punitive" systems which stifle innovation and make the recruitment and retention of caring employees an impossibility.

Prepared for the Unites States Senate Special Committee on Aging
July 28, 1998

S. Kimberly Belshé
Director
Department of Health Services
State of California

SENATOR GRASSLEY, SENATOR BREAUX AND COMMITTEE MEMBERS:

I hereby submit California's written response to your request for testimony regarding the allegations surrounding the quality of care in California nursing homes and the General Accounting Office (GAO) report created to analyze these allegations.

California takes seriously the shared responsibility with the federal government to promote the quality of care in nursing homes and takes pride in the work we do on behalf of nursing home residents. While California will continue to maintain its excellent record for providing quality care in nursing homes, we will moreover be looking to the Health Care Financing Administration (HCFA) and the federal government for guidance and funding in implementing the legislative and administrative actions recently put forward by President Clinton.

The President, Congress and HCFA have it within their power and authority to strengthen the effectiveness of nursing home oversight and thus improve the quality of care and quality of life for nursing homes in all states. California therefore challenges the President, Congress and HCFA to move forward and provide the necessary legislation and funding to protect the health, safety and security of the frail elders in nursing homes across the nation.

Nursing Home Oversight

Nursing home oversight reflects a regulatory structure that is prescribed by federal law and HCFA policy direction. While the GAO report appears critical of California's oversight in some instances, California's activities, in fact, reflect federal law and processes. All states are under contract with the HCFA to follow the statutes, regulations, and policy directives issued by the HCFA.

Generally speaking, the GAO report recognizes that the federally developed and directed survey and enforcement processes are complex. Moreover, the report validates that California has complied with the array of federal requirements. Most fundamentally, however, the GAO report highlights that certain federal policy directives have weakened the state's ability to adequately oversee the quality of care and quality of life in the nation's nursing homes.

The GAO report validates California's full implementation of the OBRA 1987 survey and enforcement process, as well as subsequent policy directives prescribed by HCFA. Had this report compared California's performance with other states, the GAO would have determined that California has been one of the most aggressive states in implementing the process, based on the quality of surveys, training of staff, number of deficiencies written and remedies imposed.

For example, California recommended and HCFA imposed $2.1 million in federal civil money penalties between February 1996 and April 1998. When requested to review proposed HCFA policy or changes to the survey or enforcement processes, California has always responded with recommendations on how the federal system can be strengthened and improved.

California as a Proactive Leader in Nursing Home Care

California's reform efforts represent a model for the nation.

Within the constraints states face in operating according to federal parameters established in statute and policy, California has sought to innovate and improve the oversight of nursing homes. This focus on innovation and improvement is consistent with California's tradition as a national leader in nursing home reform throughout the last three decades. Indeed, many of the provisions of the Omnibus Reconciliation Act (OBRA) 1987 were based on innovative, precedent-setting reforms enacted in California. Since implementing OBRA, California has sought to improve the quality of care and quality of life for nursing home residents in a number of ways:

Focused enforcement process

In 1997, California began a process to focus on facilities with poor histories of compliance. This focused enforcement process was approved by HCFA and was implemented on July 1, 1998 and for these facilities and the process:

- Shortens the survey cycle and requires revisits to verify correction
- Requires more extensive complaint investigations
- Allows no "grace period" and requires immediate imposition of remedies
- Triggers license revocation for chronic non-compliance

HCFA has shared California's approach to focused enforcement with other states.

Improved Complaint Investigation Process

On June 1, 1998 an improved complaint investigation process was implemented and this process:

- Better detects systemic problems in facilities
- Prioritizes complaint investigations in order to make sure that the most serious complaints are handled first
- Checks to make sure that other residents who might have the same conditions do not have the same care problems

All California complaints investigated are initiated within 10 days of receipt. Under federal protocols, some complaints may not be investigated until the next survey, up to 12 month away.

Criminal Background Checks

On July 1, 1998, California instituted criminal background checks via fingerprinting for all certified nurse assistants (CNAs) to help identify those CNAs whose past behavior makes them inappropriate to work with such a dependent population. CNAs are the staff who work the most closely with the frail elderly in nursing homes.

Centralized Applications

On June 1, 1998, California centralized all nursing home licensure applications. A database is being created to identify licensees with recurrent histories of noncompliance and to prevent such licensees from acquiring more facilities in California until they can sustain substantial compliance in all their facilities.

Response to the GAO Report

We acknowledge that all states have a role and responsibility as an agent of the federal government to protect nursing home residents. California shares the outrage that citizens and state and federal public officials rightly express whenever neglect or improper care comes to light. All nursing home residents deserve care that preserves individual dignity, promotes personal choice, and assures quality health care. An improved federal process would allow California and all other states the ability to better protect nursing home residents.

While California generally agrees with the findings and the four recommendations contained in the GAO report regarding the effectiveness of the federal framework for oversight of the nation's nursing homes, California has additional comments and recommendations that will be addressed later in this testimony, some of which were not addressed in either the GAO report or the Presidential initiatives.

We disagree with the recommendation to fragment the standard survey in order to inspect nursing homes more frequently. One of the strengths of the survey process is its ability to review facilities systems and practices as a whole. Fragmenting the survey would undermine the integrity of the survey process and states ability to thoroughly review

quality of care. We would prefer that HCFA fully fund the states to conduct abbreviated surveys for all complaint investigations. This would address the need to inspect nursing homes more frequently.

Further, the GAO report focused, in part, on deaths that occurred in nursing homes in 1993, two full years before the full implementation of OBRA in 1995 that included the enforcement process. If the focus of this report is on the standards and effectiveness of the OBRA survey and enforcement process, then the review should have focused on deaths that have occurred subsequent to the full implementation of OBRA in 1995. This disconnection between the GAO's focus -- the effectiveness of nursing home oversight in the context of OBRA 1987 – and the data used in part, calls into question the appropriateness of applying the report's findings to the current OBRA process, especially in 1998.

Recommendations to Improve the Federal Survey and Enforcement Process

California supports the preservation of the many positive aspects of OBRA 1987 and its implementation by HCFA. The majority of OBRA 1987 can and should be maintained. However, the President, Congress and HCFA must take seriously the challenge to strengthen the effectiveness of nursing home oversight and thus improve the quality of care and quality of life in nursing homes in all states:

Congress:

Congress must give HCFA the authority to prohibit a provider from becoming re-certified for a specified period of time after being terminated from the program. Providers whose Medicare and Medicaid certification is terminated may be re-certified within 30 days of being terminated because they are able to meet requirements at that point in time, despite a history of poor performance. Poor performers should not be allowed to apply for re-certification for a specified period of time.

Congress should authorize HCFA to add federal penalties for falsification and omission of medical record information. California requires facilities to keep accurate and complete records of care and has the ability to fine facilities that fail to do so. As pointed out in the GAO report, there are serious problems with accurate information in medical records, yet there is no federal penalty that can be applied. We believe that California's requirement should be implemented federally so that it can be part of the oversight process in all states.

Congress should provide funding to HCFA for decreasing predictability of surveys. OBRA 1987 was crafted to monitor facilities with poor compliance records more adequately and to reduce the predictability of surveys. HCFA has insufficiently funded and constricted the state's federal funding so that predictability of the survey is nearly guaranteed.

California attempts to vary the survey cycles, but the HCFA contract and the limited budget does not allow for the necessary variation in scheduling or the additional surveys that must be conducted annually to promote unpredictability in the survey cycle. California agrees that more frequent surveys in poor performing facilities is optimal. However, without the additional funding required, visiting nursing homes more often is not possible, which means that decreasing predictability is difficult.

Health Care Financing Administration:

HCFA should restore the original definitions of "isolated, pattern, and widespread" to realistically reflect the seriousness of poor care. The current definitions have the effect of lowering the severity of a deficiency and as a result, the enforcement consequences have been lowered or eliminated for some violations. These terms should be redefined to make the requirements for nursing homes more stringent.

HCFA should not accept a facility's written assurance of compliance in lieu of a revisit or imposition of remedies. Facilities that are found not in compliance should always receive a revisit to verify that all deficient practices have been fully corrected.
The decision to allow facilities to submit a written "credible allegation of compliance" -- in lieu of a revisit and/or imposition of remedies -- appears to be budget-driven and does not constitute effective regulation. There is little incentive for facilities to maintain substantial compliance when they are aware that HCFA has directed the state not to revisit them.

HCFA should recognize that actual harm may equate to substandard quality of care. HCFA should consider an option to enable states to declare substandard quality of care for actual harm, even though it may be an "isolated" incident. Incidents that cause harm to residents are no less egregious because they may have happened to only one individual.

HCFA should revise its state funding methodology to fully fund quality surveys. We recommend that HCFA determine the cost of a quality survey, not the "average" survey. Increasing the number of residents reviewed will increase state costs for conducting federal surveys, but will also increase identification of life-threatening deficiencies in care practices.

HCFA should examine the differences in survey and enforcement implementation between regions. We recommend that a "peer review" approach be considered to permit an exchange of state survey teams between federal regions and states to better understand the variances in survey data and why California and other states issue higher numbers of deficiencies. It would also facilitate state survey "best practices" that could be shared and replicated by other states.

HCFA should revise the methodology for calculating states' budgets to acknowledge the need to conduct abbreviated surveys for all complaints. There has been no federal funding

to conduct abbreviated surveys independent of the standard survey process. California places the highest priority on investigating complaints. HCFA'S policy is to "batch" all complaints (except those that pose immediate jeopardy to residents) for the next annual survey. California finds that unacceptable to continue to investigate complaints within 10 days of receipt (within 48 hours of receipt for complaints alleging jeopardy to a resident's health and safety), which exceeds federal requirements.

HCFA should revise the federal database to provide vital enforcement data. Currently, it is impossible for states to extract needed information from the HCFA database that is used to track certification and survey data. The states cannot obtain vital information on survey results, deficiencies, enforcement remedies recommended or enforcement remedies imposed. In order for states to conduct any meaningful enforcement tracking and analysis, they must use a manual system .

Summary and Conclusion

California looks forward to a productive discussion of these and other vitally important issues. We sincerely hope that future dialogue will emphasize the strengths of the existing processes and continue to build on their integrity. Should the discussion surrounding these issues begin to prey on the fears of the public and particularly of family members with loved ones in facilities, the participants would be guilty of yet another type of elder abuse. California continues to view its responsibility not only to the resident but also to family members and friends of the resident. We feel confident that California has earned and will maintain the level of trust and responsibility that family members give to us when they place their loved ones in California nursing homes.

Written Testimony of

Barbara E. Hood
President and CEO
California Association of Homes and Services for the Aging

Regarding the General Accounting Office Report
Concerning the Quality of Care in California Nursing Homes

Prepared for the United States Senate Special Committee on Aging
Hearing Date: July 28, 1998

SENATOR GRASSLEY, SENATOR BREAUX, AND COMMITTEE MEMBERS: We are pleased to submit the California Association of Homes and Services for the Aging's (CAHSA) written response to your request for testimony on the U.S. General Accounting Office (GAO) report.

CAHSA is the statewide organization representing non-profit providers of services and housing to California seniors. Our members include skilled nursing facilities, assisted living facilities, affordable housing communities, community-based organizations, and continuing care retirement communities. Our nursing home members serve over 10,000 California seniors. The majority of our members are affiliated with religious organizations. Others are sponsored by community groups, unions, and fraternal organizations. CAHSA is affiliated with the American Association of Homes and Services for the Aging.

We appreciate the opportunity to discuss the quality of care provided by California nursing homes. Nursing homes play an important role in the continuum of care. As our population ages, the need for nursing home services will increase. Our citizens deserve peace of mind that they will receive quality, compassionate caring when and if they need nursing home services. CAHSA members are committed to providing such care.

We were appalled by many of the examples of poor care cited in the GAO report entitled *California Nursing Homes: Care Problems Persist Despite Federal and State Oversight*. We believe that nursing homes with a chronic inability to provide adequate care to their residents should be closed down. The California Department of Health Service currently has authority to do so and should responsibly exercise that authority when necessary.

Caution should be taken, however, when assuming that such instances of care occur in the majority of California nursing homes. Such broad-brush assumptions do not help to identify poor performing facilities. Neither do they help to identify those qualities that make a good facility.

Malnutrition and Dehydration

We commend the committee for bringing the issue of malnutrition and dehydration in the elderly to national attention. Malnutrition and dehydration are a problem throughout the elderly population, regardless of the living situation. To truly evaluate the nutritional/hydration status of nursing home residents requires a thorough understanding of the role of malnutrition and dehydration in the natural aging and dying process. **We encourage the federal government and research organizations to allocate resources to this important issue.**

In addition, evaluating the impact of a nursing home stay upon an individual's nutritional/hydration status cannot occur without taking into consideration the status of the resident upon entering the nursing home. A resident's advance directives, which reflect the resident's most fundamental beliefs about medical intervention and the dying process, must also be taken into consideration. **The GAO investigation did not take into consideration residents' status upon admission or their advance directives.**

Professional dental care is critical to maintaining elderly persons' ability to eat. In an effort to fight fraud and abuse, California unfortunately has implemented burdensome pre-authorization procedures that unreasonably delay dental services for nursing home residents on Medicaid. These residents are typically forced to wait a month or more for dental services. Missing or poorly fitting dentures, broken crowns, cavities, gum disease, and other dental problems severely hinder a person's ability to maintain proper nutrition. Unacceptable delays in dental services for nursing home residents will not be relieved until the State revises its pre-authorization procedures. **CAHSA supports a revision of California's pre-authorization procedures for Medicaid dental services.**

Some nursing home residents require another person to feed them; others require the visual cue provided by another person who is eating that reminds them how to eat; others simply eat more when they share a meal with another. Eating is a social event, and food provides more than sustenance. Nursing homes, consequently, can always benefit from the assistance of additional staff and volunteers during meals. Unfortunately, current law prohibits nursing home staff from assisting residents with eating unless the staff member is a certified nurse assistant (CNA). **Federal law should be changed to allow staff other than CNAs to be trained and assist in feeding.**

Certified Nurse Assistants

One of the key challenges facing nursing facilities is an on-going shortage of CNAs. CNAs have physically and emotionally demanding jobs. They typically work for wages close to minimum wage and often work two jobs. Moreover, hospitals are using fewer nurses and more nurse aides. At the same time, home health care is expanding and requiring more nurse aides. Hospitals and home health agencies often attract the best and the brightest CNAs because they are able to pay higher wages.

Imposing staffing ratios on nursing homes will not necessarily improve the care provided to residents. Nursing homes are already having difficulty hiring quality staff. Requiring that they

hire more staff will only exacerbate the problem. In addition, fewer staff with a high morale can accomplish more than a larger staff with poor morale. **Our government should not impose staffing ratios on nursing homes; rather, the state and federal government should work together to increase Medicaid reimbursement, earmarking the funds for overall staffing and giving nursing homes the option to increase salaries and/or to hire more staff.**

Another hindrance to hiring quality nursing home staff is that, although the services they provide are critical to society, the job they hold is not highly respected. Blanket indictment of nursing homes unjustly demoralizes nursing home staff, making it difficult for them to have pride in their jobs and discouraging others from entering the field.

Changes Already Implemented

California has already begun implementing some of the changes recently called for by the GAO and President Clinton.

- *Focused Enforcement.* California's recently adopted "focused enforcement" process allows the State to concentrate resources on nursing homes with a record of chronically poor care. These facilities will now be required to shape up or close up. Funding, however, limits California's ability to fully implement this program. **Federal law should be changed to require states to inspect good facilities less frequently and thereby free up resources for programs such as California's focused enforcement.**

- *Background Checks.* As of July 1, 1998, all CNAs must be fingerprinted and pass a criminal background check.

- *Central Processing of Applications.* All applications to operate a nursing home are now processed through a central office. If a party already operates a nursing home and applies to operate another, the application will be denied unless the operator's existing residents are being properly cared for.

- *Care Plan Review.* California has implemented new procedures to ensure that nursing homes develop an appropriate plan of care for each of their residents.

- *Best Practices.* California has an on-going best practices program in place. **CAHSA has requested that this program examine best nutritional practices.**

Additional Comments

The best prevention against poor nursing home care is family and community involvement. Volunteers play a critical role in raising the morale of residents and staff. CAHSA supports efforts to involve families and community members in nursing homes and to empower consumers of nursing home services.

California ranks 46th in the United States for the Medicaid dollars spent per capita. High quality nursing home care requires high quality staff, which in turn requires funding. As a society, we must examine our own priorities and determine how much we value nursing services.

Conclusion

Thank you for the opportunity to comment on these important issues. We are proud of our members and the services they provide to California seniors. We believe that well performing facilities should be rewarded through less frequent surveys, innovative programs should be encouraged, and facilities with a history of chronic problems should be inspected more frequently and closed if necessary. Good public policy demands no less.

We look forward to a continued and productive dialogue on how to improve the oversight of our nation's nursing homes. If you have any questions about our comments or if we can be of assistance in any way, please contact CAHSA.

National Citizens' Coalition for
NURSING HOME REFORM

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August 7, 1998

The Honorable Charles E. Grassley
Senate Hart Office Building
SH-135
Washington, DC 20510

Dear Senator Grassley:

The National Citizens' Coalition for Nursing Home Reform (NCCNHR) Board of Directors and membership thank you and your staff for the continued interest in the plight of nursing home residents and their families. The hearings on July 27-28, 1998 and the ensuing publication of the presented and submitted testimony will continue to keep the issue before the public, Congress, and the Executive Branch.

The two issues which were a constant thread throughout both days of testimony were:

- poor enforcement, leaving residents vulnerable to neglect and abuse, and
- inadequate staffing to the point of endangering residents either directly by neglect or indirectly through falsification of records.

These issues are very complicated and NCCNHR is pleased to submit the attached document for inclusion in the hearing record.

Another immediate issue which NCCNHR would like to bring to your attention is the lack of response from the Health Care Financing Administration (HCFA) in obtaining the "nursing only" component of the per diem rate in the Prospective Payment System, which took effect under rules with comment on July 1, 1998.

At present, the nursing component of the per diem rate is combined with medical ancillaries including pharmacy, social work, oxygen therapy, laboratory services, ambulance services, radiology, and some other as yet undisclosed services. Since nursing is the mainstay of nursing home care, it is essential to have the figures in writing categorized by discipline in order to comment on the present adequacy of the per diem rate. The comments are due by September 13th. Because so much time has been wasted trying to obtain this information, NCCNHR must request another extension of the comment period until October 13, 1998. NCCNHR, in cooperation with the National Committee to Preserve Social Security and Medicare (NCPSSM), has been unsuccessful in repeated requests for this most basic information. This information will assist us in assessing the adequacy of nurse staffing in the prospective payment system. Attached is a letter written to HCFA from NCCNHR and NCPSSM.

Joan Warden, Executive Director of the National Association of Directors of Nursing Administration in Long Term Care, has also written Nancy Ann DeParle requesting this information, noting that nurses are already being terminated in anticipation of fewer revenues under the Prospective Payment System. Cost control in this industry historically begins with nursing. The evidence in your recent hearings illustrated the unacceptable effects on residents of short staffing.

We look forward to working with you on this issue and those addressed by your hearing. Please call with any questions regarding the attached testimony or the PPS staffing request.

Sincerely,

Sarah Greene Burger

Sarah Greene Burger
Executive Director

encl: NCCNHR Testimony for inclusion in the record
Letter on PPS nursing costs to Nancy Ann DeParle

cc: Martha Mohler, National Committee to Preserve Social Security and Medicare
Joan Warden, National Association of Directors of Nursing Administration in Long Term Care

TESTIMONY SUBMITTED
to the
Senate Special Committee on Aging Hearing
"Betrayal: Quality of Care in California Nursing Homes"
by the
National Citizens' Coalition for Nursing Home Reform
1424 Street, N.W., Suite 202
Washington, D.C. 20036

July 27-28, 1998

The National Citizens' Coalition for Nursing Home Reform (NCCNHR), a consumer advocacy organization seeking to improve the care and life of long term care residents, commends Senators Grassley and Breaux for their persistent efforts to keep the issues of neglect and abuse of vulnerable nursing home residents before their congressional colleagues, the public, and the executive branch. While this hearing targets California, similar problems can be found in any state. Just ten months ago a related hearing was held.

On October 23, 1997 a jointly sponsored Senate Special Committee forum on the "Risk of Malnutrition in Nursing Homes," an event requested by NCCNHR, was held in conjunction with our annual meeting of advocates and ombudsman. Family member panelists corroborated the disturbing research findings of forum speaker Dr. Jeanie Kaiser-Jones on malnutrition in nursing homes, in which she cited lack of trained professional and non-professional staff, inattention to cultural food preferences, and inability to diagnose and treat dysphasia as remediable causes of malnutrition. The Forum content is relevant to the disclosures at this hearing.

Equally as disturbing for its' similarity to today's "betrayal" is testimony by NCCNHR's founding director, Elma Holder, on October 17, 1979 at a hearing before the Subcommittee on Health and Long-Term Care of the Select Committee on Aging, House of Representatives, on "Special Problems in Long-Term Care." Nineteen years ago Ms. Holder said, " Thousands of our citizens in nursing homes will not get enough to eat today. Thousands will not be cleaned or attended to promptly or properly." She went on to say, " The regulatory system is in a state of disarray, often totally unaccountable to the public it was intended to serve. Regulatory agencies suffer from staff shortages and lack qualified staff to survey and enforce standards. Indeed, in many ways the regulatory system has been guided by the frequent presence and influence of industry spokesmen. No one else is there to give them support or to assist them in any attempt to go in the right direction. No wonder that their loyalties are directed to the providers instead of to the public."

This 1979 hearing was one of a long list of hearings culminating in the appointment of an Institute of Medicine Committee instructed to recommend ways to improve nursing home regulation. The ensuing report, *Improving the Quality of Care in Nursing Homes* was received by all stakeholders as fair. Under the leadership of NCCNHR, the recommendations in that report

for improving nursing home care were studied and discussed by representatives of fifty consumer, professional, provider and regulatory organizations and agencies. Consensus was reached one year later and presented to Congress. These consensus statements formed the basis of the Nursing Home Reform Law of 1987.

The promise of the law was that the vicissitudes of age and multiple chronic diseases would no longer be compounded by the ravages and indignities of poor nursing home care including pressure ulcers, incontinence, contractures, malnutrition and dehydration. While improvements have occurred as evidenced by decreased physical, and chemical restraint use, decreased use of urinary catheters, and increased use of hearing aides (HCFA Report to Congress: The Effectiveness of the Survey and Enforcement System, July, 1998), more than 10 years later, a crescendo of complaints from residents, family members, citizens, and ombudsman, a growing number of new citizen advocacy groups, and an increase in private lawsuits highlight the uneven care experienced by residents.

Dual reasons account for these failures in care:

- The Nursing Home Reform Act did not specify staffing ratios which would afford a minimum floor to protect residents from neglect.
- While the law specifies strong enforcement, HCFA's guidance to the states survey agencies undermines the law's requirements leaving vulnerable residents without protection. Experience tells us the partnership approach fails to hold nursing facilities accountable.

Senators Grassley and Breaux, your hearing today spoke to both those issues. NCCNHR proposes the following changes:

> **Recommendation:**
> **Require HCFA to bring the enforcement procedures in line with requirements of the Nursing Home Reform Law so that residents are protected and bad outcomes prevented.**

States and the Federal government were required to establish criteria for enforcement that:
- Specified when and how remedies were applied, the amount of the fines, and the severity of the remedies.
- Minimized the time between identification of the deficiency and imposition of the remedy. Denial of payment, temporary management, and facility closure (but not civil fines) may occur while waiting for a hearing.
- Provide for severe fines for repeated and uncorrected deficiencies.

HCFA's guidance to the state surveyors has undermined these essential enforcement elements. (Edelman, T., (1997). An Unpromising Picture: Implementation of the Reform Law's Enforcement Provisions Troubles Advocates. Quality Care Advocate. March 1997.)
These changes are balanced toward the facilities that contract with HCFA to provide a minimum

standard of care instead of protecting residents. The Nursing Home Reform Law requires compliance with the standards. These changes suggest compliance sanctions apply only to facilities that do not correct non-compliance.

HCFA POLICY DECISIONS: THE EFFECT ON RESIDENTS

HCFA Policy Decision	Effect on Nursing Homes	Effect on Residents
Allowed 30-70 days to correct deficiencies in care	Nursing home always gets a second chance - no incentive (imposition of penalty) to correct - encourages yo-yo compliance	Instead of preventing poor outcomes, residents may suffer for the full 70 days with no incentive for the facility to correct immediately
Moratorium imposed on civil money penalties - not lifted even when internal study recommended ending the practice	Industry pays no fines (money is important to industry) and has no incentive to correct	Residents may continue to receive poor care
Redefined "widespread" to include everyone in a facility	Reduces scope of deficiency thus decreasing any chance of penalty	Residents may continue to receive poor care
Introduced new terms to avoid labeling a facility as a poor performing facility	Decreases impact of deficiencies	Residents may continue to receive poor care
Surveyors instructed not to revisit facilities for certain deficiencies that HCFA (not residents) consider unimportant	No need to correct- paper compliance - This is the same type of system in place before the IOM study in 1995.	Residents may continue to receive poor care
Instructed states to use civil money penalties only for most serious deficiencies	No penalty for neglect, only for abuse	Neglect allowed to exist which leads to abuse
Informal dispute resolution allowed - resident representation at the discretion of the State Survey Agency only.	Deficiencies downgraded or removed	Residents continue to receive poor care

Recommendation:
Require HCFA to use a reimbursement strategy that holds facilities accountable for the public dollars spent on care and decrease the reliance on civil money penalties which are difficult to collect.

Regardless of a particular state's rate-setting methodology, it should not pay a facility all the money up front, but should employ a "withhold" system under which the facility does not get the first 5-10% of the rate until compliance with the law is established by the survey agency. This action would balance the power of industry money in the political process. The "withhold" system would greatly enhance the survey and quality assurance systems, because finding of non-compliance would carry a risk of losing considerable dollars which would be permanently withheld. The use of the interest from this "withhold" money would help support survey and enforcement activities which are woefully under-funded.

Federal funding for survey and certification should also be increased. The fastest way to render a government activity such as enforcement superfluous is not to fund it adequately. When frail lives are a stake, the government must assure the public that this is the last hearing needed to bring about meaningful change in the behavior of this industry.

Recommendation

Congress should pass legislation to institute a national minimum staffing level which includes:

NCCNHR NURSE STAFFING RESOLUTION

October 1995

CONSUMERS' MINIMUM STANDARD FOR NURSE STAFFING IN NURSING HOMES

Whereas people selecting a nursing home are often under pressure from managed care plans or hospital discharge planners to make quick placement decisions;

Whereas, both before and after a nursing home is chosen, residents, visiting friends and family members attempt to observe the acceptability of care;

Whereas people need guidelines to evaluate the sufficiency of nursing services when they are selecting a nursing home or judging its quality after selection;

Whereas federal and state laws require "sufficient" nursing services to meet the care needs of all residents in a nursing home, but this concept needs practical definition for the consumer, in terms of a minimum number and qualifications of staff to make possible the provision of basic direct care, supervision and planning of care;

Whereas providing "sufficient" nursing services requires maintaining an acceptable minimum staff at all times and increasing staff above the minimum to meet the special care needs of individuals;

Whereas nursing home residents have sensory and functional disability, chronic illness and changes in health status, and need nursing personnel to be available at all hours to observe and respond to their care needs, give timely, kind, and competent assistance, and notify the family and physician when there are significant changes;

THEREFORE, be it resolved that the National Citizens' Coalition for Nursing Home Reform endorses the following Consumers Minimum Standard for Nurse Staffing in Nursing Homes, as a guide to prospective and current nursing home residents, their friends and families. This is based on judgment of nurses experienced in the requirements for quality nursing home care.

FOR EVERY NURSING FACILITY:

A full-time RN Director of Nursing
A full-time RN Assistant Director of Nursing (in facilities of 100 beds or more)
A full-time RN Director of In-service Education (in facilities of 100 beds or more)
An RN nursing supervisor on duty at all time (24 hours, 7 days per week)
and

Direct caregivers (RN, LPN, LVN, or CNA)	Day	1:5 residents
	Eve	1:10 residents
	Night	1:15 residents
and		
Licensed nurses (RN, LPN, or LVN)	Day	1:15 residents
	Eve	1:25 residents
	Night	1:35 residents

These standards are only minimum and must be adjusted upwards to meet the care needs of residents. These requirements must be in place for all residents, regardless of payment source. No ongoing waivers of these standards should be allowed.

NOTE: RN= Registered Nurse LPN= Licensed Practical Nurse
LVN= Licensed Vocational CNA= Certified Nurse Aide

The most frequent complaint from consumers is lack of staff, especially on nights, holidays, and weekends. The 1996 Institute of Medicine report, *Nursing Staff in Hospitals and Nursing Homes,* recommends a registered nurse around the clock. The public would be astounded to know the presence of an R.N. is not now required. The standard, "sufficient staff to meet residents assessed needs" is difficult to enforce. In 1995, only 5.8 percent of facilities in the United States were cited for insufficient nursing staff.

Recommendation
Reauthorization of the Older Americans Act so that the ombudsman would be able to carry out their work more effectively.

The Ombudsman Program has proven to be an important and effective resource for residents and their families who experience problems in long term care facility. Over 179,000 complaints were handled in 1996, 81% of them occurring in nursing homes. One third of these complaints were violations of resident rights and another 10% involved abuse, neglect or exploitation. A 1998 AARP report indicates that while the number of nursing homes increased 10% between 1994-97, the number of paid, full-time ombudsman decreased by 5%. Ombudsmen report to NCCNHR that limited resources keep them from fully responding to consumer demand - which increases consumer frustration. Currently, each paid ombudsman serves on average 2,285 nursing home residents as well as residents in lower levels of care.

Ombudsman Programs are cost effective, utilizing more than 7000 trained volunteers at an estimated value of $18,855,460. These volunteers are absolutely essential to providing effective advocacy for long term care residents. The constraints on paid ombudsman, however, limit training and guidance that the volunteers receive.

Recommendation
Consumer report cards on each certified nursing facility that are based on the OSCAR data should be available on the Internet.

The OSCAR data includes: 1) facility characteristics, 2) resident characteristics, 3) staffing characteristics, 4) survey deficiency information, and 5) complaint data. These deficiency data are available by law to consumers; however, these are hard to obtain and written to confuse. HCFA should make the data available in an easily-useable form devised by consumers, professionals, providers, and regulators together. This information is helpful to consumers and would be an added incentive for facilities to improve.

NCCNHR thanks the Committee for the opportunity to submit this testimony for the record. Senator Grassley, Senator Breaux, you and your staff have worked diligently to see that the concerns of California citizens have been given an important hearing so that future nursing home residents will not suffer. The White House has made an important first step with the initiatives announced on July 21, 1998. This in depth hearing will serve as a catalyst for the many recommendations presented over the two days of hearings.

National Committee to
Preserve Social Security
and Medicare



July 6, 1998

The Honorable Nancy Ann DeParle
Administrator
Health Care Financing Administration
200 Independence Ave. SW Suite 314-G
Washington D. C. 20201

Dear Mrs. DeParle,

We thank you for providing a 60 day comment period on the interim final rule for Skilled Nursing Facility (SNF) Prospective Payment (PPS). This comment period is appreciated by many advocates for SNF residents.

Unfortunately, the published rule (May 12 Federal Register) does not contain information which is essential for timely comment on the adequacy of the proposed per diem rates. We write you now urgently to request this information. Specifically, for each RUG III category we need to know the nursing index and the nursing-only component of the per diem rate, and how these were calculated.

In response to requests for clarification of "nursing component" data listed in the May 12 Federal Register, HCFA provided tables showing that Nursing has been combined with "Medical" and "Ancillary" in a "Nursing, Medical and Ancillary" index and a "Nursing Med. Anc. Component" of the total per diem rate for each resident category. This makes it impossible to identify the nursing part of the proposed rates.

As you know, the nursing services department of a SNF has twenty-four hour responsibility for the care of SNF beneficiaries. Unsatisfactory care is frequently attributed to lack of sufficient nursing resources. This is a source of great concern to beneficiaries, their caregivers in SNFs and health care professionals responsible for care.

We are therefore particularly interested in seeing how well the rates provide for nursing services and how this part of the rate is calculated. In light of the July 13 deadline for comments and our inability to obtain this information thus far from HCFA, we respectfully request that this information be provided quickly to the public. We request also that you consider extending the comment period to allow thoughtful consideration of this information.

Sincerely,

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STATEMENT OF THE NATIONAL SENIOR CITIZENS LAW CENTER

SENATE SPECIAL COMMITTEE ON AGING
"BETRAYAL: THE QUALITY OF CARE IN CALIFORNIA NURSING HOMES"
July 27, 1998

The National Senior Citizens Law Center is a national nonprofit organization that represents older poor people through litigation, national policy advocacy, and technical assistance and support to advocates across the country.

NSCLC has been an advocate for nursing home residents for its entire 25 year history. We were actively involved in the development of the 1987 nursing home reform legislation, participated by invitation in the workgroup established by the Health Care Financing Administration (HCFA) in 1989 to develop the new enforcement system, and participated by invitation in one of the two external groups that HCFA convened in 1995 to monitor the federal enforcement system that was introduced in July 1995. We also joined with other attorneys in 1990 in representing a statewide class of California nursing home residents who successfully sued the state and HCFA to compel California to implement the federal nursing home reform law.

With a grant from the Commonwealth Fund, a New York-based national philanthropy, NSCLC has now spent the past year studying the federal nursing home enforcement system.

How the Health Care Financing Administration implemented the enforcement provisions of the nursing home reform law

The first part of the Commonwealth Fund project was a description and evaluation of how the Health Care Financing Administration (HCFA) implemented the enforcement provisions of the 1987 nursing home reform law. The Executive Summary of that report is attached to this statement; the full report is available on request.

We reported that HCFA's implementation of the enforcement provisions of the 1987 nursing home reform law failed to achieve the mandate of the law. Chiefly through the State Operations Manual issued in 1995 and a series of changes made to the manual after that date, HCFA weakened states' and the federal government's ability to identify and cite deficiencies and to impose appropriate sanctions for noncompliance with

federal standards of care. HCFA effectively reinstated the enforcement system that Congress had rejected and replaced in the 1987 reform legislation.

The federal enforcement system now in place looks very much like the system that Congress repudiated in December 1987 when it enacted the nursing home reform law. Now, as then, facilities are nearly always given an opportunity to correct deficiencies before they can be sanctioned for providing poor care. Enforcement is based on failure to correct deficiencies, not for providing poor care to residents. Violations of new statutory areas related to quality of life and residents' rights are virtually ignored by the enforcement system. In practice, few federal enforcement actions are actually imposed so that compliance with the new standards of care mandated by the 1987 reform law remains largely a voluntary matter.

How five states implemented the enforcement provisions of the nursing home reform law

The second part of the Commonwealth Fund project, a study of five states – Georgia, Michigan, New York, Texas, and Washington – is nearing completion. Our study confirms that the federal enforcement system has failed. States that use the federal enforcement system impose few remedies against facilities that they cite with deficiencies; states that use a different state system are more likely to sanction facilities' noncompliance with federal standards of care. Two of the states in our study illustrate this finding.

Washington enacted state legislation and had licensure rules in place by October 1, 1989, as the federal law required. The state system imposes remedies promptly when surveyors cite deficiencies. As a result, most facilities quickly correct their problems. The federal enforcement rules that became effective on July 1, 1995 had little perceptible impact on the state. Washington continued to use the state enforcement system and continued to impose remedies promptly once it identified and cited deficiencies. The federal system became a supplementary system, used primarily for facilities that failed to correct their deficiencies or that provided care posing an immediate and serious danger to residents. Most enforcement – and certainly the most rapid enforcement – continued to occur through the state's enforcement system.

Georgia also implemented the federal law by October 1, 1989, but it did so through its Medicaid program. The state imposed a considerable number of remedies under its system. During the five year period October 1, 1990 and September 30, 1995, it issued 353 bans on admissions, 52 denials of payment, 20 civil money penalties, 13 monitors, 18 temporary managers, and one termination. However, once the new federal enforcement system became effective on July 1, 1995, Georgia replaced its own system with the federal rules. As enforcement shifted from the state system to the federal system, enforcement came to a virtual halt. Since July 1995, there have been no bans on admission, no monitors, and no temporary managers imposed in Georgia by either the state or federal enforcement agency.

States' responsibility for poor enforcement

There are many reasons for the failure to enforce nursing home standards of care. The flawed federal enforcement system is a central cause, but it is not the only cause. States must also share blame for their failures to protect residents from poor care.

States have not cited the deficiencies that exist in facilities. Data compiled by Dr. Charlene Harrington of the University of California indicate that states are citing fewer deficiencies in each survey and that the number of facilities found to have no deficiencies at all is rising dramatically. At a time when complaints about poor care are increasing, these data reflect states' failure to identify deficiencies that actually exist.

State officials have not adequately supported the deficiency findings of their surveyors. Too often, they delete deficiencies inappropriately, sometimes at the request of facilities during the informal dispute resolution process. States have not done an adequate job substantiating the complaints of family members about poor care practices. They have not adequately implemented the flexible survey cycle authorized by federal law so that even if surveys are unannounced, their timing is totally predictable. States have not fully used their authority under state law to impose remedies promptly against facilities.

State survey agencies are clearly under enormous pressure. They are inadequately funded to perform the full range of survey and enforcement activities they are required to perform; many have governors who oppose strong public regulation of nursing homes; they are challenged by facilities in court and otherwise. But the fact remains that many states have not done a good job in sanctioning facilities that they know are providing poor care to residents.

Nursing facilities' responsibility for poor enforcement

While federal and state agencies are responsible for sanctioning facilities that fail to provide residents with high quality of care and high quality of life, it is of course the facilities that provide care. The nursing home industry has too often stood in the way of appropriate and necessary enforcement.

State nursing home trade associations in Michigan and Illinois filed litigation to stop the new federal enforcement system entirely. The nursing home industry encourages facilities to challenge deficiencies through informal and formal processes. It defends facilities that it knows provide poor care. It generally does not see that its own interest, as well as the public interest, would be furthered by removing poor managers and owners of facilities.

Recommendations

Our Commonwealth Fund report will recommend changes to federal and state policy that, we believe, would strengthen the public enforcement process and help improve

quality of care and quality of life for residents.

Some of the major federal recommendations are outlined here:

1. Rewrite the federal State Operations Manual in order

   - to require and assure the swift and effective imposition of remedies, as mandated by the federal nursing home reform law and regulations;

   - to reduce the excessive complexity and unnecessary paperwork in the existing system; and

   - to assure a more meaningful and appropriate relationship between the state survey agencies and federal government.

The revision of the State Operations Manual (SOM) must implement, rather than contradict, the 1987 federal nursing home reform law and the enforcement regulations promulgated in November 1994. The law requires states and the Secretary to "minimize the time between the identification of deficiencies and the imposition of remedies." It also authorizes the imposition of remedies other than civil money penalties during the pendency of an administrative hearing. Congress was direct and clear in its mandate that public enforcement agencies act quickly as soon as they identify poor care for residents.

To implement these statutory directives, the SOM must authorize and require states to impose remedies immediately against facilities at the time they first identify deficiencies. The "date certain" provision in the SOM, which allows most facilities an opportunity to correct deficiencies before sanctions are considered, must be deleted.

The SOM must also stress that imposing intermediate remedies, rather than terminating a facility from the Medicare and Medicaid programs, is generally preferable. When a facility fails to provide residents with the care they need, the management must be replaced, not the residents.

The enforcement system proposed here is required by federal law; it is also in many ways similar to the system that has been in place in Washington State for nearly a decade and is considered by all parties there to be workable and effective.

The enforcement system also needs to establish the appropriate relationship between states and the federal government and to identify and respect the appropriate roles of each.

Although the federal law imposes on the Secretary the duty for imposing remedies against facilities that participate in the Medicare program, HCFA has interpreted this statutory mandate to mean that the federal government has exclusive enforcement

authority over Medicare facilities. As a consequence, the SOM limits state enforcement authority to facilities that participate solely in the Medicaid program, an ever-smaller number. When a facility participates in Medicare, the SOM authorizes states to *recommend* remedies to the Regional Office, but says that the HCFA Regional Office *imposes* the remedies. The SOM expressly adds that "in all but the most unusual circumstances," the Regional Office is expected to impose whichever remedies the state recommends. HCFA officials have described the Regional Office as providing "rubberstamp" approval.

Such a framework – in which states do not have direct authority to impose remedies and Regional Offices do no more than attach their official seal of approval to states' recommendations – trivializes both the state and federal roles. This relationship is little more than an exercise in meaningless, superfluous, and time-consuming paperwork. The relationship also effectively nullifies statutory language that describes tie-breaking enforcement rules when state and federal officials disagree about which remedies to impose in particular situations.

State officials must have authority to impose remedies immediately and directly. Federal Regional Offices must conduct appropriate, meaningful, and binding oversight of state agency performance. They must also be available to impose remedies quickly whenever a state, for political or other reasons, is unwilling to take appropriate enforcement action against a facility.

2. Increase the federal and state survey and enforcement budgets

The federal survey budget needs to be increased so that all state agencies are given sufficient funds to conduct adequate, comprehensive, and unpredictable (as well as unannounced) surveys whose deficiency findings, if challenged, are sustained in administrative and judicial proceedings. Funding must be adequate to allow weekend and evening surveys, appropriate revisits, and timely and comprehensive complaint investigation.

The federal survey budget has not been increased for a number of years, while the survey agencies' workload has expanded enormously. States do not have sufficient funds to do the job they need to do protecting residents.

The lack of an adequate survey budget has not only hampered states. It has also led HCFA to make changes to the federal survey process that jeopardize residents. A key example is the interim revisit policy, which excuses states from revisiting facilities to determine whether they have corrected their deficiencies. Since the entire enforcement system created by HCFA in the SOM does not permit enforcement unless deficiencies are cited for a second time by the state agency at the time of its revisit, the failure to conduct a revisit means that enforcement does not occur and facilities are not held accountable for providing poor care to residents.

3. Require HCFA to convene conferences and forums, nationally and regionally, where state and federal officials can discuss practical and effective enforcement practices, techniques, and strategies.

Nearly ten years after the new enforcement systems were required to be in place, state and federal enforcement practices look much as they did before the reform law was enacted. Enforcement agencies continue to impose few intermediate sanctions, and those they impose are primarily for deficiencies in quality of care requirements. Sanctions for violations of quality of life requirements or residents' rights are especially rare. State agencies tend to impose a limited range of familiar remedies rather than the full complement of remedies authorized by federal law. Moreover, states tend to rely largely on termination for serious deficiencies. They see termination as evidence of their unwillingness to tolerate poor care rather than as a failure of their enforcement systems to take action early and to protect residents from poor care. Enforcement is also typically viewed in a vacuum, disconnected from reimbursement and other factors that influence provider behavior. Enforcement is generally focused on individual facilities, not on corporate owners.

While there are examples of states' creative and effective use of intermediate sanctions against individual facilities and systems-wide enforcement against corporate owners, these instances are not widely known. State officials seem to know very little about what their peers are doing. HCFA must convene meetings and forums to enable state and federal enforcement agencies to learn best practices in enforcement from each other, the research community, experts, and advocates. HCFA must also establish a webpage for best practices in survey and enforcement, as it has recently established a webpage for best practices in facilities.

The President's initiative

On July 21, the President announced a new Initiative to Improve the Quality of Nursing Homes. The three-page outline of the Initiative released on July 21 identifies a number of the issues identified here:

- the need to impose remedies immediately upon a finding of serious noncompliance;
- the need to strengthen surveys by making surveys less predictable and by conducting weekend and evening surveys;
- the need to target chains that have poor records of compliance;
- the need to prosecute egregious violations of care practices through civil and criminal investigation and prosecution, when appropriate; and
- the need for increased federal oversight of state surveys.

Additional recommendations by the President that we strongly endorse include reauthorization of the nursing home ombudsman program under the Older Americans Act; increased attention to issues of pressure sores, dehydration, and malnutrition; and making survey reports more easily and quickly available to the public through publication of survey findings on the internet.

At the President's press briefing on July 21, the President and Secretary Shalala also released the report that HCFA had written pursuant to Congressional direction in the 1996 appropriations bill. Although we have not yet had an opportunity to read the entire 900 page report, we are aware of, and support, its three primary findings:

- that deemed status for private accrediting agencies, endorsed by the nursing home industry as a replacement for a public regulatory and enforcement system, cannot adequately protect residents and must be rejected as a public policy option;

- that there is no evidence to support the effectiveness of nonregulatory quality initiatives and that such initiatives, endorsed by the nursing home industry as replacements for a public regulatory and enforcement system, must also be rejected as a public policy option; and

- that there is evidence that the public regulatory and enforcement system can work and that it needs to be strengthened to assure that all residents receive high quality of care and high quality of life.

We look forward to seeing the detailed policy changes that HCFA will issue to implement the President's Initiative and to working with the agency to assure that the Initiative, and the mandates of the 1987 reform law, are fully realized.

Conclusion

We thank Senator Grassley and the Senate Special Committee on Aging for holding these hearings to bring attention to continuing serious problems in nursing homes and the need to strengthen public oversight and enforcement activity. We also thank the President for his new Initiative that recognizes the shortcomings in the existing enforcement system and calls for substantial and fundamental changes to strengthen it. The Initiative, as outlined by the President, holds considerable promise for residents and their families.

We are hopeful that the attention brought to these concerns last week and this week will quickly lead to a strengthened public regulatory system, to increased federal funding for these important regulatory activities, and ultimately, and most importantly, to better lives for our nation's million and a half nursing home residents.

WHAT HAPPENED TO ENFORCEMENT?
EXECUTIVE SUMMARY

A Study of Enforcement under the Nursing Home Reform Law
Funded by the Commonwealth Fund

The Federal Government's implementation of the enforcement provisions of the nursing home reform law fails to achieve the mandate of the law. Since the federal enforcement provisions became effective on July 1, 1995, nearly seven years after the statutory deadline for their implementation, the Health Care Financing Administration (HCFA) has made a series of changes that continue to weaken the regulatory system. In the post-regulatory phase, HCFA reinstated principles and concepts in the State Operations Manual that Congress had explicitly rejected in the reform legislation. And since implementing the new enforcement system on July 1, 1995, it has continued to revise its informal guidance in a variety of ways that undermine state and federal governments' ability to sanction facilities that provide deficient quality of care or quality of life to residents. The federal enforcement system now in place looks remarkably like the system that Congress repudiated nearly 10 years ago, in December 1987, when it enacted the nursing home reform law. Now, as then, facilities are nearly always given an opportunity to correct deficiencies before they can be sanctioned for providing poor care to residents. The failure to correct deficiencies, rather than the existence of deficiencies, is the basis of enforcement. Deficiencies in the new statutory areas of residents' rights and quality of life are virtually ignored by the enforcement system. And, in practice, few federal enforcement actions are actually taken so that compliance with the 1987 nursing home reform law remains largely a voluntary matter.

Nursing home enforcement has come to resemble the system that Congress criticized – and redesigned -- in 1987 for three principal reasons. First, efforts to reduce the federal budget deficit have reduced federal spending on discretionary programs, resulting in a lack of sufficient resources to enforce public standards at the federal and state levels. Second, HCFA, like the rest of the Executive Branch, has philosophically moved away from a regulatory orientation and towards a collaborative, nonregulatory, corporate model of quality improvement. As a consequence, state and federal agencies see their role as *encouraging* facilities to improve the care they provide, rather than as *sanctioning* facilities that fail to meet statutory quality standards. And finally, HCFA has succumbed to the pressure and demands of the nursing facility industry to reduce regulatory oversight and public accountability.

Principles of enforcement in the law

The reform law, enacted by Congress in December 1987, fundamentally changed the principles for enforcement of federal standards of care. The law required that all states enact a specified list of intermediate remedies and not rely exclusively on termination. It required that remedies be imposed for violations of residents' welfare and rights, as well as residents' health and safety. It mandated that certain mandatory remedies be imposed for repeated or uncorrected deficiencies. It required that states have enforcement systems to "minimize the time between the identification of violations and final imposition of the remedies." And it disapproved a consultant role for surveyors.

These provisions were not reached by consensus, as were most quality provisions in the statute. They represented a compromise, a combination of the different approaches set out in the House and Senate bills.

Since the reform law was enacted, the nursing home industry has battled enforcement and sought to weaken the strong enforcement orientation of the legislation. Although HCFA added the industry's two main points to the final regulations which had not appeared in the proposed rules -- it created a new regulatory term, "substantial compliance," that would tolerate some level of deviation from full compliance with Requirements of Participation and it required states to have some type of informal dispute resolution process -- the industry has been most successful in the post-regulatory phase of implementation of the reform law.

State Operations Manual (June 1995)

In the State Operations Manual (SOM) issued in June 1995 to implement the final regulations that were published in November 1994, HCFA created a new term -- date certain -- that allows most facilities (other than those subjecting residents to immediate and serious jeopardy or those identified as "poor performing provider" [another new SOM term]) time to correct deficiencies after the survey agency identifies and cites deficiencies. If deficiencies still exist at the time of the revisit, then the state agency may recommend that remedies be imposed by the Regional Office. In practice, most facilities are given an opportunity to correct their deficiencies.

Informal Changes since July 1995

Since issuing the State Operations Manual in June 1995, HCFA has informally made a number of changes to the survey and enforcement processes.

On June 29, 1995, HCFA imposed a moratorium on the collection of certain lower level civil money penalties (CMPs). The moratorium was subsequently revised. HCFA now claims to have lifted the moratorium, effective January 1997, in a companion memorandum to its revision of its new guidance on civil money penalties, discussed below. However, since the new guidance encourages

states to reevaluate the CMPs that were subject to the moratorium since July 1995 using the new criteria, HCFA's actions in fact have the effect of making the moratorium permanent.

On September 12, 1995, HCFA issued a memorandum "clarifying" the definition of "widespread" scope to limit use of the term to deficiencies that affect all residents in an entire facility. Deficiencies affecting all residents on a particular wing or all residents with a particular problem cannot be cited as widespread.

On November 27, 1995, HCFA created new terms to define facilities that are not in substantial compliance: "correction required" and "significant correction required." HCFA created these new terms specifically in order to avoid labeling facilities with the stigma of an official statement of noncompliance.

On December 6, 1995, HCFA issued an Interim Revisit Policy that permits states to avoid revisits in facilities that have deficiencies cited at lower levels on the federal enforcement grid. Since the enforcement system in the SOM relies on revisits to impose remedies, the lack of revisits means that enforcement is not even theoretically possible for these deficiencies. Most deficiencies in quality of life and residents' rights are cited, if at all, at the lowest levels of the enforcement grid. Consequently, the Interim Revisit Policy means that states are unlikely to impose remedies for deficiencies they identify in quality of life and residents' rights.

In December 1996, HCFA issued another revision to the SOM that encourages states, effective January 24, 1997, not to impose CMPs when they cite deficiencies at the two lower levels on the four-level enforcement grid. CMPs are to be limited to situations of immediate jeopardy or to nursing facilities that are "poor performers" or have "serious deficiencies" that are not corrected at the time of a revisit.

A June 1997 revision to the SOM modified the informal dispute resolution process, giving new authority to facilities to challenge the scope and severity of certain deficiencies, contrary to the survey process introduced in July 1995, which prohibited facilities from challenging scope and severity determinations under all circumstances. The revision also encouraged states to offer facilities telephone or face-to-face meetings and to include as a decision-maker at least one person who was not involved in the original survey.

Data

When HCFA published the final enforcement rules in November 1994, it anticipated that the new enforcement system would lead to considerably more enforcement activity than the prior system. That expectation has not been realized. Instead, while deficiencies are cited, very few federal enforcement actions are actually imposed. In

the second full year of the survey process, the number of remedies imposed, with the exception of civil money penalties, actually declined.

In addition, between 1991 and 1996, the average number of deficiencies per survey declined and the percentage of facilities with no deficiencies cited at all increased. These patterns continued when the new survey and enforcement processes went into effect.

Conclusion

The first two and a half years of the enforcement system have seen HCFA respond to providers' concerns and ignore residents' concerns. HCFA redefined terms of noncompliance to please providers, redefined "widespread," dealt quickly with states that cited more deficiencies than the norm, limited CMPs to serious deficiencies, and gave facilities additional opportunities to challenge survey findings in the informal dispute resolution process. The agency has not taken comparable action to respond to residents' concerns about states that cite few or no deficiencies nor has it issued any guidance to correct states' practice of citing deficiencies at too low a level on the grid.

As implemented by HCFA, the federal enforcement system has not achieved the promise or the mandate of the nursing home reform law.

Feb. 23, 1998

NUTRITION SCREENING INITIATIVE
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*For identification purposes only

August 10, 1998

Senator Chuck Grassley
Chairman
Senate Special Committee on Aging
105 Hart Senate Building
Washington, DC 20510

Dear Senator Grassley:

Thank you for including this letter and the attached fact sheets in the Congressional Record pertaining to the June 26 and 27 Senate Special Committee on Aging hearings, Betrayal: The Quality of Care in California Nursing Homes.

The Nutrition Screening Initiative applauds the Senate Special Committee on Aging for calling attention to the needs of elders in nursing facilities. While we agree that federal oversight and enforcement of existing quality care standards is critical, we hope the Committee will look for ways to systematically improve the provision of routine nutrition care inside nursing facilities.

As the Committee continues its work to improve the quality of care provided to our nation's elders, the Nutrition Screening Initiative asks you to keep several points in mind:

1. The demands of caring for an older and sicker population are becoming increasingly complex. The practice of geriatric medicine is still in its infancy. For many areas of care, such as nutrition care, new standards of quality care and practice guidelines must be integrated in OBRA regulations, accreditation standards, reimbursement policies, and training of professionals and volunteers caring for elders in nursing facilities. Currently, the Minimum Data Set collects patient information; it does not assess patient status or measure quality care.
2. Studies have observed 54% to 85% of elders are malnourished when they enter nursing facilities. Nutrition screening, assessment and the incorporation of medical nutrition therapy and other nutrition interventions into patient care plans has to become routine for every nursing home resident.

Initiative funded in part through a grant from Ross Products Division, Abbott Laboratories

3. Nutrition care is more than feeding. It encompasses nutrition screening, assessment and, most importantly, a range of interventions that, in addition to "food based" interventions, include medications management, psychological and social counseling, physical therapy, and dental treatment. Attention must be paid not only to staffing of patient feeding programs but to insuring that dietitians and nurses provide nutrition care, before nutrition-related health problems reach crisis levels.
4. Poor nutritional status can be a symptom of natural disease progression. Therefore, weight loss does not always indicate poor quality care. Weight loss which goes undetected is an indicator of poor quality care. Again, we encourage you to recommend that nursing facilities routinely conduct nutrition screening and be held accountable for incorporating medical nutrition therapy into patient care plans when appropriate. Reimbursement policies need to be changed so this vital care is provided.
5. While most pressure ulcers can be prevented, even the most vigilant nursing care may not prevent the development and worsening of ulcers in some very high-risk individuals. In those cases, intensive therapy must be aimed at reducing risk factors (such as improving nutritional status), at preventive measures (such as frequent turning and mattress overlays), and at treatment. However, when an individual is in the latter stages of a terminal illness and is suffering intractable pain, the primary goal of therapy may be to promote comfort and decrease pain. In this case, frequent repositioning, nutritional support, and other strategies to prevent pressure ulcers may not be consistent with the goal of promoting comfort.

We urge the Senate Special Committee on Aging to devote at least as much attention to promoting solutions as you have to exposing the problems of poor quality care in America's nursing facilities. The majority of nursing homes deliver quality care, including nutrition care, to their residents. If model nutrition care programs with continuous quality improvement are promoted, these achievements in quality care can be replicated by nursing facilities nationwide.

Enclosed are several fact sheets providing an overview of the nutritional status of both institutionalized and non-institutionalized older Americans and the challenges poor nutritional status presents the nation's health care system. These fact sheets again clarify that if we want to maintain the nutritional status of elders in nursing facilities current regulations related to nutrition care must be strengthened. Nutritional status must be monitored and appropriate interventions provided as elders progress through the entire health care system.

Thank you for your consideration.

Sincerely,

Deborah Clark

Deborah Clark
Director



NUTRITION SCREENING INITIATIVE

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Malnutrition in Nursing Facilities:
The Responsibility of Every Health Care Provider

Malnutrition in nursing homes, who is to blame? Do nursing homes neglect the nutritional needs and preferences of elders?

While instances of neglect are few and far between and do not represent the vast majority of providers, negligence can occur. The unfortunate reality is that poor care sometimes occurs in nursing facilities, as it does throughout the health care system. Of almost equal misfortune are the exposés that attempt to taint an entire industry with broad brush strokes that diminish the trust older persons and their families have in nursing facilities and divert attention from solving the very real problems of caring for an extremely vulnerable population.

"The nutrition-related health problems we see in nursing facility residents are the cumulative result of insufficient nutrient intake and the physical, mental, and social problems that compromise their health status and their capacity to take care of themselves," explains Polly Fitz, MA, RD, President of the American Dietetic Association.

In Long Term Care, Nutrition Care Requires Additional Emphasis

Currently, 1.6 million increasingly frail Americans live in long-term care facilities, a number that is anticipated to rise sharply as the country ages. About 40% of people currently aged 65 can expect to enter a nursing facility at some time.

Care for older adults in long-term care facilities must meet two goals: maintenance of health and quality of life. Quality nutrition care is a key component in any facility's ability to successfully meet these goals. Improving and maintaining nutritional health is often a formidable task that requires the skills of a multidisciplinary care team.

Residents have individual nutritional needs that may require therapeutic diets, texture-modified foods, nutrient-modified foods or medical nutrition products. Some residents need assistance eating. Others require interventions related to oral health, mental health, medication use, or underlying medical problems. Additionally, nursing facilities must meet the needs and desires of an increasingly diverse population.



AMERICAN ACADEMY OF FAMILY PHYSICIANS



THE AMERICAN DIETETIC ASSOCIATION



NATIONAL COUNCIL ON THE AGING, INC.

Initiative funded in part through a grant from Ross Products Division, Abbott Laboratories

Quality nutrition care should include an in-depth nutritional assessment and development of a resident nutrition care plan. This is crucial for nursing facilities, where resident needs frequently change and interdisciplinary care must be coordinated. Frequent meetings of the nutrition care team are needed to evaluate and refine the medical and nutrition care plans. Quality nutrition care must be tailored to an individual's needs, preferences and functional limitations. Dietitians are integral to successful assessment, interventions and evaluation that enables the care team to meet individual needs.

Nutrition-Related Health Problems Escalate with Age

Nursing facilities, by definition, care for the most frail and chronically ill people in the country. To improve the nutritional status of facility residents, the health care system must examine and improve the provision of nutrition care across all care settings.

"More than ever before, the care of elders is fragmented, shifting from short, frequent hospitalizations to rehab and home care then back again. To prevent the downward spiral of nutritional status in nursing facilities, policy makers and health care professionals must work collaboratively to prevent malnutrition before and after stays in these facilities," explains Bruce Bagley, MD, Chair of the American Academy of Family Physicians Commission on Health Care Services.

Nutrition-related health problems cause considerable dysfunction and disability, decreased quality of life and, in many cases, increased morbidity and mortality. Malnourished older Americans get more infections and diseases; their injuries take longer to heal; surgery on them is riskier; and their hospital stays are longer and more expensive. Older Americans who develop nutrition-related health problems are more likely to be institutionalized, especially when community services like meal programs, shopping assistance, and home support are not available or utilized.

Dr. Bagley emphasizes the intrinsic value of nutrition care, saying, "Good nutritional status will help maintain or improve the functional status of older persons. This not only improves their quality of care, but their quality of life as well." Appropriate and timely medical nutrition therapy, when warranted, can improve nutrition status and prevent morbidity and high health care costs associated with malnutrition, such as pressure sores and dehydration.

The Commitment of All Health Care Providers is Required

"If we want to maintain the nutritional status of elders in nursing facilities, nutritional status must be monitored and appropriate interventions provided as they progress through the health care system," says Nancy Wellman, PhD, RD, Chair of the Nutrition Screening Initiative. Organizations representing the broad spectrum of parties interested in the nutritional health of older persons and the health care professionals caring for older persons must focus attention and collaborate on "best practices of nutrition care" to maintain and improve the nutritional health of America's elders.

Practical Steps to Enhance Nutrition Care in Nursing Facilities

Nutrition care consists of more than just serving meals. Quality nutrition care must be based on an assessment of the individual's nutritional status and the provision of nutrition interventions that address each person's medical, emotional, psychological, and social needs.

Incorporate a multidisciplinary team approach. Physicians, dietitians, nurses, pharmacists, therapists and aides all have tremendous responsibilities and input in improving the nutritional status of residents.

Emphasize the importance of nutrition care. Explain to staff the crucial nature of nutrition care and its effect on maintaining and improving health status.

Assess **nutritional status**. Evaluate the individual nutritional needs of residents who may require therapeutic diets, texture-modified foods, nutrient-modified foods or nutrition supplements. Speech language pathologists and dietitians can screen each new resident's chewing and swallowing abilities to determine whether texture modifications are needed.

Develop and monitor resident care plans to address medical, social, economic and personal risk factors including: inappropriate food intake; poverty; social isolation; dependence/disability; acute/chronic disease or conditions; medication use; mental health; and oral health.

Provide staff orientation on facility standards of nutrition care. Clear expectations, efficient communications systems, strong relationships with center staff, residents and their families are essential to successful nutritional care.

Educate about enteral feeding and medical foods. With increasing age, disabilities and diseases, it is important that residents, families and staff know about the choices and decisions that must be made when eating by mouth is not feasible.

Bolster nutrition support during illness by incorporating the use of supplements during medications pass. A nurse or certified medication assistant can offer 2 ounces of a high calorie medical nutritional supplement, rather than water or juice, with medications 3 or 4 times a day as prescribed. Several nursing facilities have reported weight gain, better appetites at meal time and improved meal consumption for patients participating in the program.

Liberalize diets. Diet modifications should focus on texture modifications based on the resident's ability to chew and/or swallow. Diets that restrict sodium, fat or sugar can sometimes diminish appetites and total calorie intake.

Interview residents upon admission about food preferences, eating and cooking habits, family traditions, religious customs or cultural food preferences.

Incorporate family style dining. Give patients who eat independently at least one family-style meal a day. With staff supervision, pass food in serving bowls rather than trays. This technique is very successful with Alzheimer's residents and may help others enjoy meal time more.

Develop restorative meal programs. Patients who are not yet independent with dining skills can be supervised by an occupational therapist to reinforce self-feeding techniques, proper positioning and posture, and use of adaptive equipment (e.g. weighted utensils, non-slip materials to keep dishes on the table, handles that help diminished grips). Finger foods such as carrots or chicken nuggets can also increase a patient's sense of independence.

Take an "all hands on deck" approach to dining. Encourage all staff to help get residents to the dining hall and/or assist with eating. If a patient needs to be walked for 20 minutes, spend 20 minutes walking to the room for meals.

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A Profile of Nursing Facility Residents: Vulnerable to Malnutrition and Nutrition-Related Health Problems

Among persons aged 65 years, about 40% can expect to enter a nursing facility at some time. Slightly half of these older adults are expected to stay in a facility for at least 1 year and about one-fifth may stay at least 5 years. (Reuben)

The most rapidly growing segment of the population is the age group 85 years of age or older; this age group also has the highest rate of institutionalization, approximately 25%. (Reuben)

Between one-quarter and one-third of nursing facility residents have a low Body Mass Index, while 10 - 14 % experience significant weight loss. A low BMI and severe weight loss are sometimes unavoidable symptoms of clinical conditions such as end stage renal disease, chronic obstructive pulmonary disorder, cancer, or congestive heart failure, or the result of a resident's end-of-life directives to refuse artificial nutrition and hydration. (Hawes)

Approximately 70% of nursing facility residents have some type of organic brain disorder usually accompanied by dementia. (AARP)

Confusion, the single most common symptom of brain disorder, affects 44% of residents. These residents may also suffer from anorexia and involuntary weight loss, conditions that occur more frequently outside the long-term care facility (66%) before their admission. (Bartlett)

Long-term care residents ingest an average of 8 medications per day. Of the more frequently used medications, 23 are known to cause reduced food intake and have side effects such as anorexia, nausea, vomiting, food aversions, somnolence and disinterest in food. (Bergstrom)

As many as 50% of Americans have lost all their teeth by the age of 65. Poor oral health can contribute significantly to nutritional decline. (Fisher)

It is estimated that 40% to 60% of older adults in long-term care facilities may experience dysphagia during eating. Nutrition restrictions, coupled with sensory losses, may result in limited food enjoyment and compromised food intake. (The American Dietetic Association)

As many as 50% of nursing facility residents need help with 4 or more activities of daily living. (Fisher) As Medicare and Medicaid eligibility criteria become more stringent, only the sickest patients will be admitted to nursing facilities, causing the patient populations to be even more debilitated and medically unstable. (Fisher)

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A Profile of Nursing Facility Residents: Vulnerable to Malnutrition and Nutrition-Related Health Problems – page 2

The incidence of eating disability in nursing facilities is high. One survey documented that 50% of skilled nursing facility residents require eating assistance. (Varma)

Among older adults in nursing facilities, pressure ulcers are associated with a fourfold increased risk of death. Although pressure ulcers have multiple causes, nutritional status is a contributing factor. One study found that baseline nutritional status is one of the best predictors in pressure ulcer healing. (Bergstrom)

The single best predictor of death within 6 months in a malnourished patient in a nursing facility is a cholesterol level below 150mg/dL. (Morley)

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Nutrition-Related Health Problems Among The Elderly: Expensive & Preventable

Older Americans, due to the many environmental, social, economic and physical changes of aging, are at disproportionate risk of poor nutrition that can adversely affect their health and vitality. The American population will increase by almost 50 percent from 1995 to 2050, while the 65 and older age group will increase by 135 percent. There are currently over 3 million Americans over 85. This number is expected to reach over 8 million by 2030, and over 18 million by 2050. The population of Americans age 85 and over will increase by 401 percent from 1995 to 2050. (AAHSA)

Even though older Americans currently make up only 13% of the population, they consume 36% of the country's health care resources. Maintaining the good health and independence of this population is critically important to the stability of the U.S. health care system. (US Department of Health and Human Services)

Randomized, controlled clinical trials have shown that malnourished older Americans get more infections and diseases (Weinier); their injuries take longer to heal (Kay); surgery on them is riskier (Buzby); and their hospital stays are longer and more expensive than well-nourished patients (Reilly). Malnourished patients take 40% longer to recover from an illness (Riffer); have two to three times more complications (Buzby); have hospital stays that are 90% longer and $5,000 more costly per medical patient and $10,000 more costly per surgical patient (Riffer); and are re-admitted to hospital earlier and more frequently (Riffer).

In 1993, a national survey commissioned by the Nutrition Screening Initiative of 750 geriatric doctors, nurses and administrators of hospitals, nursing homes and home care agencies reported that *one in four* of their elderly patients suffer from malnutrition as do *one half* of elderly hospital patients and *two in five* nursing home residents. (Hart)

Poor nutritional status among America's seniors includes not only nutritional deficiencies, dehydration, undernutrition, and nutritional imbalances, but also obesity and other excesses such as alcohol abuse. In addition, inappropriate dietary intakes for conditions that have nutritional implications and the presence of an underlying physical or mental illness with treatable nutritional implications are common treatable problems. (US Preventive Services Task Force)

A report of the U.S. Senate Committee on Education and Labor stated that "85% of the older population have one or more chronic conditions that have been documented to benefit from nutrition interventions." (US Congress, Committee on Education and Labor)

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In *Healthy People 2000: National Health Promotion and Disease Prevention Objectives*, nutrition screening was emphasized as a necessary, routine component of primary care because so few physicians or other health professionals ask about nutrition. (US Public Health Service)

As a component of nutrition care, nutrition screening makes early intervention possible, thus ensuring timely access to health services, preventing serious nutrition-related health problems and promoting management of chronic diseases and good health. (Coombs)

The Lewin Group projects the net cost of extending coverage of medical nutrition therapy to all Medicare beneficiaries at less the $370 million over seven years, when savings are considered. After the third year of coverage, the study estimates that savings would be greater than costs. The study projects that the initial investment required to Medicare Part B, which covers outpatient care, will yield significant savings to Medicare Part A, which covers inpatient costs. The total savings to the Medicare program come from reduced hospital admissions and reduced complications requiring a doctor's visit. (Lewin Group)

A 1996 study conducted by the Barents Group of Peat Marwick documents that the consistent and appropriate use of medical foods for hospitalized patients prevents complications in the treatment of those critically ill and injured. The study estimated the routine provision of medical foods would save $1.3 billion in health care dollars by the year 2002. Nutrition intervention for a wide variety of diseases and conditions including hip fracture, cardiovascular diseases, pulmonary and renal infections, and endocrine and metabolic disorders were found to be clinically and cost effective. (Barents Group)

Federal programs to combat hunger and food insecurity reach only one-third of needy older adults. (Burt)

The cost of providing nutritious home-delivered meals to a person for 1 year equals the cost of one in-hospital day. (The American Dietetic Association)

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Older Americans: Disproportionately at Risk for Poor Nutritional Status

Risk factors for poor nutritional status are characteristics or occurrences which indicate that someone is at risk for or is already in a poor nutritional state. Risk factors for older Americans include: inappropriate food intake; poverty; social isolation; poor mental health; poor oral health; dependence/disability; acute/chronic disease or conditions; medication use; and advanced age. The greater the number of these risk factors, and the longer they persist, the greater the likelihood that poor nutritional status will ensue. (Dwyer)

In 1993, a national survey commissioned by the Nutrition Screening Initiative of 750 geriatric doctors, nurses and administrators of hospitals, nursing homes and home care agencies reported that *one in four* of their elderly patients suffer from malnutrition as do *one half* of elderly hospital patients and *two in five* nursing home residents. (Hart)

About 9.4 million older people live alone. Nearly half of Americans over the age of 85 live alone. (AAHSA) Being with people daily has a positive effect on morale, well-being and eating.

As many as 50% of Americans have lost all their teeth by the age of 65 years. Poor oral health can contribute significantly to nutritional decline. (Fisher)

One of every five older persons has trouble walking, shopping, buying and cooking food. (Nutrition Screening Initiative)

An evaluation of the Elderly Nutrition Program of the Older Americans Act (congregate and home delivered meals) indicates that 67 % to 88 % of the participants are at moderate to high nutritional risk. One survey found that almost two-thirds of those responding had a weight outside the healthful range and that 18 % to 32 % had involuntarily gained or lost 10 pounds within 6 months before the survey. (Ponza)

41% of congregate and 59% of home-delivered meal participants reported having three or more diagnosed, chronic illnesses or conditions. (Ponza)

It is estimated that 40% of older adults have inappropriate dietary intakes of 3 or more nutrients. Poorly nourished adults have higher morbidity and mortality rates than do their optimally nourished counterparts. (White)

Only 13% of older adults eats the minimum amount of fruit and vegetables recommended by the Food Guide Pyramid. (Nutrition Screening Initiative)

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Older Americans: Disproportionately at Risk for Poor Nutritional Status - page 2

Approximately 3.7 million (11.7%) elderly persons live below the poverty level. Another 2.2 million (7%) of older Americans are considered "near poor." (AAHSA)

National projections from local surveys by the Urban Institute indicate that 2.5 - 4.9 million older adults experience food insecurity, the inability to access a nutritionally adequate, culturally compatible diet. (Burt)



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A Profile of Nursing Facilities: A Record of Problems and Progress

As defined by the American Health Care Association, long-term care services target persons who have lost the capacity to function on their own as a result of chronic illness or conditions that require intervention for an extended period. Assisted living, sub-acute rehabilitative care facilities, and nursing facilities all fall within the rubric of long-term care. There are 16,995 nursing facilities in the US.

1.6 million increasingly frail Americans live in long-term care facilities, a number that will rise sharply as the country ages.

Since 1985, the number of nursing facilities decreased by 13 % while the number of beds increased by 9%. The number of nursing facility residents was up only 4 % between 1985 and 1995, despite an 18 % increase in the population aged 65 years and over. Many older adults receive care at home, leaving only the most frail elders to reside in nursing facilities.

Enacted by Congress in 1987, the Omnibus Budget Reconciliation Act (OBRA) reforms made substantial ongoing changes to the rules that apply to facilities that receive Medicare and/or Medicaid funding. Among the problems addressed in OBRA are deficiencies in food service, sanitation and attention to the nutritional needs of residents.

OBRA-87 reforms sought to shift the survey process from focusing on a facility's paper compliance to focusing on resident-centered outcomes. The new monitoring systems were expected to provide more accurate information on the day-to-day lives of residents and a more accurate picture of the adequacy of a facility's performance.

The mandated resident assessment inventory (RAI) includes a multi-page Minimum Data Set (MDS) that assesses resident's health status including oral and nutritional status. In addition, for residents with nutritional risk factors or problems identified on the MDS, the RAI suggests that additional, highly focused assessments and resident assessment protocols (RAPs) be completed to identify reversible or treatable causes of nutritional problems and guide care plan decisions.

OBRA-87 reforms also specified the development and implementation of an enforcement system that was intended to provide the states and federal government with tools that would encourage facilities to attain and maintain compliance with the quality of care standards.



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The percentage of facilities cited for deficiencies under the regulations covering 1.) dietary services, and 2.) and nutritional adequacy of meals have dropped from 15% of the facilities in 1991 to 9% and 5%, respectively in 1996.

Since the implementation of OBRA-87, there have been overall improvements and improvements in the quality of nutritional care and in related resident outcomes. A greater proportion of residents with nutritional problems or risk factors now have some type of care plan in place to address malnutrition and dehydration. And somewhat fewer residents are malnourished now, compared to the period prior to OBRA-87.

Variations still exist among facilities in the proportion of residents with potential nutrition-related problems. While some variation may be associated with differences in resident case mix, it is extremely unlikely that great disparities are associated only with the underlying mix of residents. It is much more likely that these disparities represent real differences in the quality of care and services provided. It suggests that the care practices provided in the best scoring facilities can reasonably be applied more broadly, and improved nutritional status can be realized for many nursing home residents.



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Definitions of Nutrition Care

Poor Nutritional Status includes not only deficiency, dehydration, undernutrition and nutritional imbalances, but also obesity and other excesses such as alcohol abuse. In addition, inappropriate dietary intakes for conditions that have nutritional implications and the presence of an underlying physical or mental illnesses with treatable nutritional implications are included. Finally, it also encompasses evidence that nutritional status may be deteriorating over a patient's life. Such evidence may be derived from clear-cut objective clinical signs, by nonspecific clinical evidence, by responses to direct, specific questions about diet and nutrition (even if complaints are not volunteered), and by reliable reports from third parties (family, friends, caregivers, and social workers).

Risk Factors of Poor Nutritional Status are characteristics that are associated with an increased likelihood of poor nutritional status. They include the presence of acute or chronic diseases and conditions, inadequate or inappropriate food intake, poverty, dependence/disability, and chronic medication use.

Indicators of Poor Nutritional Status are generally quantitative and provide evidence that poor nutritional status is present. Indicators include dietary, clinical, anthropometric, and biochemical parameters, as well as the existence of nutrition-related conditions or diseases. Changes in indicators are usually quantifiable, and, if abnormal to a certain defined extent, mandate consideration of nutritional factors. Minor indicators are less specific and/or quantifiable, and include some individual specific nutritional deficits.

Nutrition Screening is the process of identifying characteristics known to be associated with dietary or nutritional problems. Its purpose is to differentiate individuals who are at high risk of nutritional problems or who have poor nutritional status. For those with poor nutritional status, screening reveals the need for an in-depth nutrition assessment which may require medical diagnosis and treatment as well as nutrition counseling, as a specific component in a comprehensive health care plan.

Nutrition Assessment is the measurement of indicators of dietary or nutrition-related factors to identify the presence, nature, and extent of impaired nutritional status of any type, and to obtain the information needed for intervention, planning and improvement of nutritional care.



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Definitions of Nutrition Care – page 2

Nutrition Intervention is an action taken to decrease the risk of or to treat poor nutritional status. Nutrition interventions address the multifactorial causes of nutritional problems and therefore include actions that may be taken by many different health and social service professionals as well as family and community members. A wide range of intervention actions, from utilization of congregate meal programs and home care services, to dental services and pharmacist advice, to nutrition education and nutrition counseling, to specialized medical and/or dietary treatment, e.g. enteral nutrition therapy, are all examples of nutrition interventions.

Medical Nutrition Therapy is a part of a patient's overall medical care. It is the process that dietitians , physicians and other trained health professionals use to assess the patient's nutritional status and optimize nutrient intakes, either through diet modification and counseling or specialized medical feeding. Medical nutrition therapy may, but does not always, include the use of medical foods.

Nutrition Education imparts information about foods and nutrients, diets, lifestyle factors, community nutrition resources and services to people to improve their nutritional status.

Nutrition Counseling provides individualized guidance on appropriate food and nutrient intakes for those with special needs, taking into consideration health, cultural, socioeconomic, functional and psychological factors. Nutrition counseling may include advice to increase or decrease nutrients in the diet; to change the timing, size, or composition of meals; to modify food textures; and, in extreme instances, to change the route of administration - from oral to feeding tube to intravenous.

Nutrition Support is the alteration of usual food intake by route of administration modification of nutrient content, nutrient density or food consistency. Nutrition support always includes nutrition counseling; it often includes the use of medical nutritional supplements which may be given orally, and the provision of enteral or parenteral nutrition. Individuals who may benefit from nutrition support are those who can not, should not or will not eat a nutritionally adequate diet. It is especially important when dietary intakes are inappropriate for conditions that have nutritional implications especially when underlying physical or mental illnesses with treatable or nutritional implications are present.

Enteral Nutrition involves the administration of nutrients via feeding tubes in people with functional GI tracts; as opposed to *parenteral nutrition* (also known as intravenous feeding) which involves the direct administration of nutrients into the blood stream.

Medical Foods are a specific form of specialized therapy administered orally or through feeding tubes under a physician's supervision for the dietary management of a medical disorder, disease or condition. Some medical foods are disease specific and may provide levels of certain nutrients that aid in the treatment of specific diagnoses.

References

American Association of Retired Persons, A Profile of Older Americans. Administration on Aging. 1992:2-4.

American Association of Homes and Services for the Aging. http://www.aahsa.org/ members/aging.htm

American Dietetic Association. Position of The American Dietetic Association: Liberalized diets for older adults in long-term care. Journal of the American Dietetic Association. February, 1998.

Barent's Group. The Clinical and Cost-Effectiveness of Medical Nutrition Therapy: Evidence and Estimates of Potential Medicare Savings from the Use of Selected Nutrition Interventions. Nutrition Screening Initiative, 1996.

Bartlett, BJ. Characterization of anorexia in nursing home patients. *Educ Geron.* 1990, 96:361-369

Bergstrom N, Braden, BJ, Laguzza A, Holman V. The Braden scale for predicting pressure sore risk. Nurs. Res. 1987;36:205-210.

Burt MR. Hunger among the elderly: Local and national comparisons. Washington, DC, The Urban Institute, 1993.

Buzby GP, Mullen JL, Matthews DC, et al: Prognostic nutritional index in gastrointestinal surgery. Am J Surg 1980; 139:160-167.

Coombs J. Nutrition screening and intervention programs meet challenges to provide quality and cost-effective care for geriatric patients. Man. Care Quarterly; 6(2):1-00.

Dwyer JT. Screening Older American's Nutritional Health: current and future possibilities. Nutrition Screening Initiative, Washington, DC. 1991.

Fisher J, Johnson M. Low body weight and weight loss in the aging. J Am Diet Assoc. 1990;90:1697-1706.

Fowles DG. A Profile of Older Americans: 1995. Washington, DC, American Association of Retired Persons and USDHHS Administration on Aging, 1995.

Hart Research Associates. National survey on nutrition screening and treatment for the elderly. Washington, DC 1993.

Hawes, C. US Senate Special Committee on Aging, October 22, 1997

Kay SP, Moreland JR, Schmitter E: Nutritional status and wound healing in lower extremity amputations. Clin Orthop 1987;[April (21)]:253-256.

Lewin Group. Significant Medicare savings with medical nutrition therapy. RDs improve health care and reduce costs. Chicago: ADA Courier, May, 1997.

Morley, JE, Mooradian, AD, Silver, AJ, et al: Nutrition in the elderly. Ann Intern Med 109:890, 1988.

Nutrition Screening Initiative. DETERMINE Your Nutritional Health Checklist.

Ponza M, Ohls JC, Millen BE. Serving elders at risk: the older Americans act nutrition programs, National evaluation of the elderly nutrition program, 1993 - 1995. Washington, DC: Mathematica on Policy Research, Inc; 1996.

Position of the American Dietetic Association: cost-effectiveness of medical nutrition therapy. J Am Diet Assoc. 1995;95:88-91.

Reilly JJ, Hull SF, Albert N, et al: Economic impact of malnutrition: A model system for hospitalized patients. JPEN 1988;12:371-376.

Reuben D. Chronic Care Initiatives in HMOs, American Association of Health Plan. Medical Affairs Issues Reports. 1997.

Riffer J: Malnourished patients feed rising costs: Study. Hospitals, 1986 p 86.

US Congress, Committee on Education and Labor. May 16, 1995

US Department of Health and Human Services, Washington, DC: 1990.

US Preventive Services Task Force. Guide to Clinical Preventive Services, 2nd ed. Williams & Wilkins, Baltimore, pp. 794-796, 1996.

US Public Health Service. Healthy People 2000: National Disease Prevention and Health Promotion Objectives. 1994.

Varma RN. Risk for drug-induced malnutrition is unchecked in elderly patients in nursing homes. J Am Diet Assoc. 1994;94:192-194.

Weinier RL, Hunker EM, Krumdieck CL, Butterworth CE: Hospital malnutrition: A prospective evaluation of general medical patients during the course of hospitalization. Am J Clin Nutr 1979;32:418-426.

White JV. The Role of Nutrition in Chronic Disease Care. Nutrition Screening Initiative. Washington, DC. 1997.



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TESTIMONY OF

Bettty Bednarcyzk, International Secretary-Treasurer
Service Employees International Union, AFL-CIO, CLC

SUBMITTED TO

The Special Committee on Aging
United State Senate

July 27, 1998

My name is Betty Bednarcyzk and I am the International Secretary-Treasurer of the Service Employees International Union (SEIU). Our 1.3 million members include more than 100,000 nursing home workers in more than 1,000 nursing homes across the country. Earlier this year, I also had the honor of serving as a member of the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry. This commission deliberated over many of the issues that your committee is discussing today which pertain to both acute and long term health care.

SEIU commends the Special Committee on Aging for devoting needed attention to the quality of care in our nation's nursing homes. It is our hope that the work of this committee and the new initiatives announced by the Administration last week will result in stricter enforcement of existing standards that can improve quality of life for senior citizens and people with disabilities in nursing homes.

Quality of care in nursing homes is vitally important to our union because the nurse assistants we represent witness first hand the abuses in this industry, including the shortages of supplies, dangerous working conditions and inadequate staffing that create barriers to their ability to provide residents with the care they deserve. Through our Dignity, Rights and Respect Nursing Home Campaign, we are actively working with advocates, consumers and other coalition partners to improve resident care and working conditions.

Improving the quality of care in nursing homes will require ensuring that there are: 1) enough staff to sufficiently meet resident's needs, 2) staff that are fairly compensated, experienced, and well trained and 3) a safe working environment. Therefore we recommend:

- Specific Minimum Staffing Ratios for All Care-Giving Staff
- Staffing Standards Linked to Acuity
- Disclosure of Staffing Ratios
- Higher Wages and Better Benefits for Nursing Home Workers
- More Training and Better Supervision for Certified Nurse Aides
- Moving Forward with OSHA's Proposed Ergonomics Standard

SEIU Report on Resident Care

Just last week we released a report on the quality of resident care in facilities operated by Genesis Health Ventures. We are particularly concerned about the quality of care in facilities run by these types of for-profit chains, who are under increasing pressure to cut costs as they respond to new competitive pressures. This report, *"Rolling the Dice: Quality of Failures at Genesis ElderCare,"* found that between 1994 and 1998, 140 of 319 Genesis homes were cited 1,652 times for failure to meet minimum federal resident care requirements, and that between 1995 and 1998, one third of all Genesis facilities reviewed were found to be substandard at some time. These and other findings raise troubling questions about the predictability and consistency of care at the fifth largest nursing home chain in the United States.

These findings are even more disturbing in light of Genesis Health Venture's plan to win exclusive contracts with managed care organizations. Under these agreements, managed care consumers may be required to choose a Genesis facility for post-hospital care, or risk paying higher out of pocket costs for treatment elsewhere. In response to the consolidation within this industry we recommend that state regulators should view chain facilities such as Genesis homes as part of a comprehensive network, rather than as individual entities, in evaluating the quality of care residents receive in those facilities and in fashioning remedies for deficient or sub-standard care[1].

The track record of homes such as those run by Genesis Health Ventures underscore the need to strengthen and improve the inspection process, as the Administration recommended last week. We firmly support that Administration's call for increased inspections of repeat offenders, surprise inspections on evenings and weekends, civil fines for each case of serious or chronic violations, and public disclosure of inspection reports.

Short Staffing In Nursing Homes

Strengthening enforcement mechanisms alone will not ensure quality of care. Many of the problems identified by state inspectors in the Genesis homes related to short staffing. Violations often stem from too few care-givers taking care of too many residents. This is what nursing home workers have been telling us for many years. They tell us that when not enough aides are scheduled, and workers who can't come in are not replaced, residents don't get the care they need:

- Residents don't get turned or repositioned every two hours.
- Residents are not fed properly.
- Residents don't have their hygiene needs met.
- Residents are not walked or given adequate range of motion exercises.

As a result:

- They develop bedsores or are unnecessarily restrained.
- They lose weight and may become malnourished.
- They lie in their own urine and feces.
- They develop contractures or suffer other deterioration.

These reports are consistent with the findings of the Institute of Medicine's (IOM) Committee on the Adequacy of Nurse Staffing in Hospitals and Nursing Homes who found in 1996 that: "*The preponderance of evidence from a number of studies using different types of quality measures has shown a positive relationship between nursing staff levels and quality of nursing home care, indicating a strong need to increase the overall level of nursing staff in nursing homes.*"[2]

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[1] The use of the term substandard conforms with the definition used by the DHHS.

[2] Nursing Staff in Hospitals and Nursing Homes, Is It Adequate ? Institute of Medicine, National Academy Press, Washington DC, 1996.

A large part of the problem is the shortage of Certified Nurse Aides (CNAs) who provide 80 to 90 percent of the resident care.[3] This is not a new issue. Back in 1986, the IOM highlighted this problem: *"To hold down costs, most of the care is provided by nurse aides who, in many nursing homes are paid very little, receive relatively little training, are inadequately supervised and are required to care for more residents than they can properly serve."*[4]

Ten years later, in their 1996 report, the IOM continued to underscore the shortage in nurse aides: ***"In some nursing homes there is a clear need for more nurse aides to provide bedside care... Inadequate nurse aide staffing leads to increased risk of medical complications and expense, intermittent discomfort from hunger and thirst, escalated need for even more nursing care, and sensory and psychological deprivation."***[5]

The consequences of short staffing affect patient care in numerous ways. The persistent understaffing causes stress and job dissatisfaction which leads to high turnover rates. Annual turnover rates for CNAs in nursing homes reached 100.4% as of January of 1994.[6] With the current low unemployment rate, employers around the country are complaining about the inability to find enough CNAs. The implications for resident care are devastating. Studies illustrate that residents do not cope well with frequent changes in staff, and that excessive turnover of these personnel, heavy use of part-time staff, and the use of floating or agency staff also compromise the quality of care.[7] Another problem is the skyrocketing rate of injuries to nursing home workers.

Because nursing home workers are often called upon to lift and move patients, it is not surprising that the most prevalent form of injury is back injury. Back injuries account for a higher percentage of all injuries in nursing homes than in other industries, with CNAs particularly at risk. OSHA inspections in 1992 of a number of nursing home chain facilities in Pennsylvania found that short-staffing was forcing CNAs to perform many patient lifts and transfers alone.[8]

The dangerous conditions created by understaffing hurt residents who suffer from poor continuity of care and increased safety risks; hurt workers who suffer from the pain

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[3] Improving the Quality of Care in Nursing Homes, Institute of Medicine, 1986, pg. 52.
[4] Ibid pp 11
[5] Nursing Staff in Hospitals and Nursing Homes, Is It Adequate ? Institute of Medicine, National Academy Press, Washington DC, 1996.

[6] National Data on Turnover collected by the American Healthcare Association, 1994b, 1995.
[7] Nursing Staff in Hospitals and Nursing Homes, Is It Adequate ? Institute of Medicine, National Academy Press, Washington DC, 1996, pp. 159.
[8] Data from record evidence cited in DOL's Brief to OSH Review Commission (filed May 1, 1996) in Secretary of Labor v. Beverly Enterprises, Inc. (OSHRC Docket 91-3344, 92-0238, 0819, 1257 and 93-0724)

and long lasting effects of back injuries and other ailments, and also hurt employers and taxpayers who must pay increased workers compensation costs.

Higher Acuity Levels Exacerbate the Staffing Crisis

The jobs of CNAs have become more demanding and stressful over the past five years due to the change in medical conditions of residents. Nursing home workers tell us that they are seeing an increasing number of sicker residents who need help with ADLs such as eating, and toileting; older residents in their 90s and above who are very frail; residents with Alzheimer's disease and other cognitive disabilities; and young residents with AIDS and other contagious diseases.

Our members are concerned that they do not have the time or training necessary to provide excellent, high quality care to these residents. Several trends, including the growth in home and community based care, and an increase in sub-acute care in nursing homes explain the higher level of acuity in nursing homes that our workers are describing. The result of these trends is that more and more of the "easier to care for" residents are staying at home or in the community at the same time that hospitals are releasing patients "quicker and sicker" to cut costs and patients with more acute and complex medical conditions are discharged into nursing homes.

Several changes in Medicare spending patterns reflect the dramatic increase in acuity. In 1991, only 4.7 percent of nursing home residents were Medicare funded, whereas in 1996 that had grown to 8.6 percent.[9] The increase in Medicare residents is also reflected in the growth of Medicare-certified skilled nursing facilities. From 1984 to 1994, the number of Medicare-certified facilities has almost doubled from 5,760 to 11,436. And Medicare payments to skilled nursing facilities increased 28.2% from 1994 to 1995.

Residents Require More Staff Time But Staffing Levels Have Not Increased

Despite the rising demand for nursing staff, staffing levels have not substantially increased in recent years. In fact, according to a recent analysis by noted gerontologist Charlene Harrington and others, staffing levels for CNAs, who provide the bulk of the time-consuming hands on care, has actually ***decreased***.[10]

The study analyzed average hours per resident day in all certified nursing facilities in the U.S. over a five year period, 1991 - 1996. The data from this time period illustrates that while licensed nurse hours increased slightly, from 1.0 to 1.1 per resident day, total nursing staff hours stayed constant at 3.0 per resident day. Further, it illustrates that CNA hours actually decreased from an average of 2.0 hours per resident day in 1991 to 1.9 hours per resident day in 1996.[11]

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[9] HCFA, Survey Certification and Reporting Data, Table 6.

[10] Harrington, Charlene Ph. D. et al., Nursing Facilities, Staffing, Residents and Facility Deficiencies, 1991 Through 1996., January 1998.

Ibid, Table 29, pp. 69

In recognition of the rising acuity levels in nursing homes and varying levels of care required, Medicare and many state Medicaid programs have moved to case-mix reimbursement systems that award higher rates for residents who need more care. But, while these systems pay more for heavier care residents, they do not require that extra staffing is actually being provided to meet their needs. This means that while the homes are getting reimbursed at higher rates for some residents, the incentive for the home is to staff as low as possible and profit from the difference.

Recommendations

I commend this committee for investigating the alarming and growing problem of poor quality of care in our nation's nursing homes and I also urge members of this committee to acknowledge that quality can not be significantly improved without addressing the staffing crisis. Addressing this crisis requires the following:

1) Enough staff to sufficiently meet resident's needs.

Recognizing that resident care can be improved by increasing staff levels, the IOM Committee recommended in 1996 that Congress require 24-hour coverage by RNs in certified nursing facilities by the year 2000.[12] We agree with this requirement, which is increasingly important given the rising acuity levels and increasing number of residents with complex health care needs. However, standards for RN's alone will not address the inadequacy of staffing overall. Minimum standards must also be set for CNAs and other nursing staff who provide the vast majority of hands on care. Therefore, we recommend:

- **Specific Minimum Staffing Ratios for All Care-giving Staff**

Nursing homes will not voluntarily increase staffing to adequate levels. Therefore, it is essential that the government establish minimum standards for all levels of nurse staffing in every single home.

Standards should be in the form of ratios so that they are easily observable and enforceable. The National Citizen's Coalition for Nursing Home Reform has proposed standards for direct caregivers (RN, LPN, LVN or CNA) to residents which are 1:5 days, 1:10 evenings, and 1:15 nights; and standards for licensed nurses (RN, LPN or LVN) to residents which are 1:15 days, 1:25 evenings, and 1:35 residents. We believe that these are the minimum standards and they should always be considered as a floor not a ceiling.

It is also important that regulatory approaches ensure that minimum staffing ratios are enforced on a floor or unit level to guarantee adequate staffing across the facility. Unless this is the case, there is the danger that a facility with a high acuity unit that required 8 or 9 hours of nursing home care per resident day may understaff in other units and still be able to meet the legal requirements.

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[12] Nursing Staff in Hospitals and Nursing Homes, Is It Adequate ? Institute of Medicine, National Academy Press, Washington DC, 1996, pp. 154.

We acknowledge that establishing national minimum staffing standards would require the political will to identify new funding sources for increasing reimbursement rates. In 1996, the IOM report referred to the cost involved, saying: *"It is clear that substantial improvements in the quality of nursing home care are not possible without the allocation of increased financial resources for additional and appropriately qualified staff."*[13]

In addition to pushing for federal standards, opportunities to improve staffing standards at the state level should also be pursued. The majority of states have specific staffing standards in addition to the federal standards for RN's in nursing homes. Unfortunately most of these standards were set years ago and have become increasingly inadequate over time.

- **Staffing Standards Linked to Acuity**

Case mix reimbursement systems increase resources for residents with higher levels of acuity but they alone are ineffective in improving care for these higher acuity residents. Without a mandated link between reimbursements and staffing levels, there is no guarantee that nursing homes will use the enhanced rates to meet the demand for increased staffing levels posed by higher acuity patients. Therefore we recommend:

  - Case mix systems, including state systems and Medicare, require that the increased reimbursement to meet the care needs of higher acuity residents be actually spent on staffing and;
  - The staffing levels established through these reimbursements systems be adequate to meet the care needs of the residents.

- **Disclosure of Staffing Ratios**

Because staffing levels are closely linked to the quality of care, nursing homes should be required to disclose their nursing staff ratios. The format for disclosure should be easily understandable to residents and their friends and families. This information should be posted by shift and floor / wing so that consumers and potential consumers can see at a glance the number and type of staff at any point and time providing care for their loved one.

2) Staff that are fairly compensated, experienced, and well trained.

Quality care requires more than having the right number of staff to handle the work load. These staff must also be experienced and skilled at what they do. Unfortunately, in the nursing home industry, this is too often the exception rather than the rule because the turnover rates are so high. Turnover rates of more than 100% are not surprising given the low wage levels for nursing home workers.

RN's, LPN's and CNAs are all paid appreciably less in nursing homes than they are in hospitals.[14] The mean hourly wage for CNAs is $6.72 per hour[15], which is less than

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[13] Ibid pp. 168.

[14] Nursing Staff in Hospitals and Nursing Homes, Is It Adequate ? Institute of Medicine, National Academy Press, Washington DC, 1996, pp. 160.

average hourly wages for housekeeping cleaners ($6.84), crossing guards ($7.19), and telemarketers ($8.99); and much less than photo copy machine operators ($9.57), butchers ($10.60) and parking enforcement officers ($11.80).[16] Even fast food cooks, although they may start earning less, have more opportunity for promotions and pay increases than in a nursing home.

In addition to low wages, most nursing facilities do not provide health and retirement benefits. [17] According to CPS data, more than half (52%) of people working in jobs related to the care of elderly do not have employer-based health care coverage in their name and must rely on coverage under a spouse's plan, Medicaid or go without.[18] Many of our members are offered health care benefits but can not afford to accept them, either for themselves or for their families, because the co-payments and premiums are too high. This is consistent with the results of a recent survey conducted for the AFL-CIO which found that more than three quarters of the decline in employer health coverage across industries resulted from growing premium contributions required of employees.[19]

To reduce turnover, and nurture a seasoned, professional work force, we recommend:

- **Higher Wages and Better Benefits for Nursing Home Workers**

Our union will continue to organize workers and bargain for wage increases. But fundamental change will require policy changes and legislative action. With more than 50% of revenues to nursing home coming through Medicaid and Medicare, policy makers should consider policies to ensure that a certain percentage of this funding is passed through employers to workers to ensure fair compensation for their front line workers.

This can be done, as in Michigan, by earmarking a certain amount of existing funds for wage and benefit increases. Or, it can be done as in Minnesota, by earmarking a portion of any increase in reimbursement to improving the wages or benefits of nursing home workers.

In addition, nursing home workers deserve affordable health and retirement coverage. Some facilities have reduced turnover by providing health insurance and other benefits such as free on-site child care.[20] Those homes that do offer health care benefits

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[15] Hospital and Health Care Compensation Services, John Zabka, Oakland, New Jersey, 1997

[16] Bureau of Labor Statistics, National Employment and Wage Data from the Occupational Employment Statistics Survey by Occupation, 1996.

[17] Nursing Staff in Hospitals and Nursing Homes, Is It Adequate ? Institute of Medicine, National Academy Press, Washington DC, 1996, pp. 160

[18] Economic Policy Institute, Washington DC, results from the 1995 and 1996 census surveys and March 1997 supplement data tabulations.

[19] Paying More and Losing ground, How Employer Cost-Shifting Is Eroding Health Coverage of Working Families, survey conducted by the Lewin Group, Inc. for the AFL-CIO, February, 1998.

[20] Nursing Staff in Hospitals and Nursing Homes, Is It Adequate ? Institute of Medicine, National Academy Press, Washington DC, 1996, pp. 142.

should keep co-payments to a minimum so that workers can afford to accept coverage for themselves and their families.

- **More Training and Better Supervision for CNAs**

The President's Commission on Consumer Protection and Quality in the Health Care Industry called for "minimum standards for education, training and supervision of unlicensed paraprofessionals."[21] In the nursing home industry, minimum training requirements already exists but they do not adequately prepare CNAs to face the challenges that the job presents. The meager training requirements and poor supervision likely to contribute to the high turnover rates for CNAs.

Training requirements for CNAs include 75 hours of classroom training and practical skills training as well as annual in-service continuing education. Some industry observers, however, argue than 75 hours (roughly two weeks) of training is insufficient to fully cover the material that workers should know and that the in-service trainings are often attended by too many workers to make them useful.[22]

To put the meager training requirement in perspective, consider that hairdressers and manicurists are required to attend 1,500 hours at an accredited school in order to get a license[23], while the people who feed, dress and monitor the health changes of our parents and grandparents in nursing homes have less than two weeks of training.

To address the problem of insufficient training, this committee should look at what an increase in classroom and on the job training would be appropriate as well as make recommendations about ways to improve the in-service trainings and supervision by licensed nurses.

3) A safe working environment

To address the alarming rate of back injuries, workplace violence and other hazards, we recommend that:

- **OSHA's Finalize Proposed Ergonomics Standard.**

Over the past few years, OSHA has been developing an ergonomics standard for private sector employers which would provide clear guidance on how to prevent disabling injuries and require employers to develop an injury prevention program. Strong opposition from industry groups has stalled this effort. We urge OSHA to proceed with the development of the standard and to ensure that the new standards include coverage of all industries, including the nursing home industry.

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[21] Advisory Commission on Consumer Protection and Quality in the Health Care Industry, Report to the President, Chapter Thirteen, Engaging the Health Care Workforce, March 1998.
[22] Home Care Associates Training Institute, written testimony to the Advisory Commission on Consumer Protection and Quality in the Health Care Industry, Subcommittee on Quality Improvement Environment, September 9, 1997.
[23] Children's Defense Fund web site, www.childrensdefense.org/ccfact.html, November, 1997.

This committee has an historic opportunity to improve the lives of nursing home residents and improve working conditions for nursing home workers so that they can provide the highest quality care possible. We appreciate your leadership and look forward to working with you and your staff.



Joint Commission
on Accreditation of Healthcare Organizations

Statement of the

Joint Commission on Accreditation of Healthcare Organizations

To: Senate Special Committee on Aging

Hearing July 27-28, 1998

Betrayal: The quality of Care in California Nursing Homes



Joint Commission
on Accreditation of Healthcare Organizations

STATEMENT FOR THE RECORD

by the

Joint Commission on Accreditation of Healthcare Organizations

before the

U.S. SENATE SPECIAL COMMITTEE ON AGING

Hearing on

"BETRAYAL: THE QUALITY OF CARE IN CALIFORNIA NURSING HOMES"

July 27-28, 1998

We would like to thank Chairman Grassley and other members of the Special Committee on Aging for this opportunity to present the views of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) on the quality of care in nursing homes. First, we would like to offer support for your responsible efforts to keep the important issue of care for our the elderly and other residents of long term care facilities clearly before the American people. The Joint Commission has had a long standing interest in the quality of care provided by health in care organizations, and since 1951, has been the private sector's leading standard-setting body for the health care industry.

We find it regrettable that the Health Care Financing Administration (HCFA), facing severe criticism by the Government Accounting Office for its own inspection and enforcement process for nursing homes, found it necessary to issue as part of its response to that criticism a negative report about the advisability of relying upon private sector accreditation. Given the highly charged political climate surrounding nursing home enforcement, coupled with HCFA's reliance on long term care appropriations to support its certification budget, it is not surprising that the findings of its report to Congress offer an unfavorable view of the role of private sector accreditation in the oversight of nursing homes. The timing of the release of the HCFA report, coupled with the unsupportable conclusions in its Executive Summary, compel the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) to submit this statement for the record.

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Member Organizations
American College of Physicians
American Dental Association
American Hospital Association

The Joint Commission wishes to present to the Committee a brief summary of the significant reasons why the report's conclusions are unfounded, and to raise for your consideration certain questions concerning the motivation and timing behind the report's release. Unfortunately, the brief amount of time between the release of the report and the close of this hearing record does not permit us to provide in this statement a more detailed analysis of all of the points raised by the HCFA study. Further, the difficulty imposed by the short time frame was exacerbated by HCFA's refusal to identify the specific 12 nursing homes in the study group that led to the most negative statement in their report. We expect to complete our empirical analysis by September, 1998.

It is also significant that the report shifted focus from its original intent to evaluate the role that private sector accreditation could play in a constructive partnership with HCFA for improving long-term care oversight. Instead, the report presented an evaluation of the Joint Commission as if the accreditation survey had been performed in lieu of a Medicare nursing home survey. Because the Joint Commission does not have long-term care deemed status, such a comparison is at best misleading. Moreover, the Joint Commission would never wish to replicate HCFA's flawed enforcement process for nursing homes. Our expectations for a HCFA/JCAHO partnership involve bringing the strengths of the Joint Commission's measurement knowledge and survey expertise to the Medicare program in a manner that improves quality of care, disseminates best practices, and brings value to publicly funded programs.

Private sector accreditation is never a replacement for enforcement processes. Rather, accreditation can support and improve enforcement programs, and lead to the achievement of quality of care goals that regulatory approaches can never attain.

The information presented in this statement underscores the value that accreditation could play in a public/private sector partnership for improving the quality of care in Medicare certified nursing homes. The Joint Commission believes that a partnership that optimizes the strengths of each party should be a public policy goal. Enforcement mechanisms have not been proven successful. A positive approach to achievements in the delivery of high quality care is essential. In addition, government programs have extraordinary difficulty in remaining at the cutting edge in the area of standards development, and they cannot match the expertise and credentials of private sector surveyors. Nor is the governmental survey process as cost-effectiveness as private sector accreditation. Therefore, it is in the public interest to construct a framework that provides incentives for quality improvement, and that uses the private sector to assist HCFA with its evaluations. Such a framework would bring more value to the

governmental processes by enhancing the nature of oversight that is performed on behalf of the public at taxpayer expense.

In the following pages, the Joint Commission hopes to briefly respond to the 1998 HCFA "Report to Congress: Study of Private Accreditation (Deeming) of Nursing Homes, Regulatory Incentives and Nonregulatory Initiatives, and Effectiveness of the Survey and certification System," and present information that will be helpful to the Committee in future deliberations.

The scientific integrity of the study is flawed

The HCFA report contains six findings in its Executive Summary relative to the issue of deeming private sector accreditation for purposes of assessing compliance with Medicare Conditions of Participation for long term care facilities. These findings are based upon flawed analytic work, misinformation, and incorrect judgments about the Joint Commission's standards and survey processes.

When comparing HCFA and Joint Commission standards, the study used both HCFA's regulatory standards **and** HCFA's Guidelines to Surveyors. In distinction, the study only included a portion of the corresponding JCAHO requirements: it evaluated the JCAHO standards but failed to consider some of the key intent statements that accompany the accreditation standards, and neglected to include any of the Joint Commission special surveyor guidelines.

The study's side-by-side comparison of a cohort of HCFA and Joint Commission survey reports failed to note the areas where the Joint Commission found deficiencies and HCFA did not. In fact, the comparison was so biased as to ignore numerous instances where the Joint Commission findings were similar or more severe than those found by HCFA, and to omit an important situation where the Joint Commission denied the accreditation of one nursing home, but HCFA continued to certify the facility.

Six areas of comparability between Joint Commission standards and HCFA regulations were identified as problematic in the report. In these areas, the Joint Commission standards were presented as incomplete, or divergent from Medicare regulations. Yet **all** of the concerns raised are actually addressed in JCAHO standards.

HCFA makes highly charged statements about instances where HCFA found significant problems in some of the 179 nursing homes in the study and the Joint Commission did not find the same problems. Yet HCFA fails to tell the reader the fact that in the majority of those cases, HCFA was the first survey team in the door. Consequently, one would not expect the Joint Commission to find the same problems 30 to 90 days later, because those problems should have been corrected in accordance with HCFA's own regulatory time frames.

HCFA failed to report that in the majority of cases where HCFA completed its survey before the Joint Commission review took place, the Joint Commission found more problems, and more serious problems, than when HCFA was the second in the door. This casts doubt on HCFA's capacity to discern and effect quality improvement in a comprehensive set of areas, because the Joint Commission survey occurred shortly after the departure of the HCFA surveyors.

HCFA fails to demonstrate the superiority of either the HCFA or the Joint Commission approach, yet HCFA uses a broad brush in the Executive Summary to paint a negative picture of accreditation's contribution to quality oversight. Such negative conclusions are suspect given the study's own statement about the methodologic problems in doing a fair Joint Commission/HCFA evaluation: "The focus of each of the two systems is sufficiently different that the standards and regulations are not consistently comparable on a point by point basis. A single HCFA 'F' Tag often corresponds to more than one Joint Commission standard and, in some cases, to as many as 27 or 28 standards...the differences in the words and terms used in the Joint Commission standards and in the HCFA regulations are sufficiently different to confound the comparison of one system to another." - (page 165 of the report.)

Accuracy of the report was not a priority

Many of the report's errors, especially those in the data analysis sections, could have been avoided by allowing Joint Commission review and comment on the preliminary findings as had been the agreement with HCFA. Acquiring such input is an integral ingredient to a well implemented study protocol involving data analyses, especially when those analyses involve data sources not completely familiar to the researcher(s). On this point, the Joint Commission agreed to the study methodology on condition that it would have such an opportunity to provide feedback to the researchers as a mechanism to ensure that a comprehensive analysis of JCAHO-provided information was performed.

Understanding the complexities inherent to a comparison of two different survey processes, the Joint Commission specifically asked to review the criteria for data abstraction of JCAHO survey reports and to provide feedback after the initial data analysis was completed. The Joint Commission was assured by the researchers, Abt Associates, that the request was very reasonable and important to the integrity of the study, and that the request would be honored. Despite HCFA's repeated agreement to allow Joint Commission input, HCFA chose to release the report under premature circumstances. In so doing, HCFA missed the opportunity to correct flagrant errors and have a meaningful report. At the same time, avoiding Joint Commission feedback on the preliminary analysis gave HCFA the freedom to make unsupportable statements about the accreditation process.

Rebuttal of the six findings

Following are the six findings in the executive Summary of the report to Congress and the response of the Joint Commission on Accreditation of Healthcare Organizations:

Finding #1. *The Joint Commission would have to change several standards to assure that Medicare requirements were met.*

This is a very disingenuous statement, implying an inadequacy of the Joint Commission standards. It fails to note that in a deeming relationship with HCFA, the Joint Commission would agree to survey for the Medicare requirements as part of its evaluation of those nursing homes wishing to be Medicare certified. Clearly no deeming relationship exists now. Although the Joint Commission does not survey using the current Medicare requirements, it has imbedded all of their associated data tags into the JCAHO accreditation manual for long term care facilities, placing them in the sections of the manual that correspond to JCAHO standards. This is done to assist Joint Commission accredited organizations in understanding HCFA requirements in order to prepare themselves for Medicare certification surveys. The Joint Commission surveyors can thereby give guidance to accredited nursing homes about federal certification requirements and assist them in achieving both private sector and governmental objectives.

Most egregiously, the comparison done between HCFA and Joint Commission standards was slanted toward HCFA's favor, because they failed to consider all of the Joint Commission requirements. Specifically, all of the HCFA requirements were used, including HCFA standards and the associated guidelines to surveyors, but only a portion of the JCAHO instructions to surveyors were evaluated. For example, Abt did not include a section of the accreditation manual called "Specific Certification Requirements." This section was placed in the 1996 accreditation manual to serve as a crosswalk of HCFA regulations and Joint Commission standards. The majority of issues raised by Abt were addressed in that section. A comprehensive crosswalk of HCFA requirements and Joint Commission standards reflects a high degree of comparability which would be further enhanced in a deemed status relationship.

The report identified six "areas of concern" where Joint Commission standards diverge from HCFA regulations. Yet all were addressed in Joint Commission standards. To illustrate the imperfect analysis done in just one of those areas -- #4 Lack of Clarity Regarding Use of Medication:

HCFA indicates that F329 (HCFA data tag) address the use of psychotropic medications with specific parameters and standards. HCFA believes that JCAHO standards refer to *"antipsychotic* medications, not psychotropics." HCFA believes that F329, F330, and F331 make a clear distinction between the two types of drugs and their uses. (Note: The study reverses the underlined terms in its findings).

What the analysis fails to point out is that antipsychotic drugs are actually a **subset** of psychotropic medications. Therefore, HCFA is making a distinction without a difference. JCAHO uses the term psychotropic because it is the broader category of drugs and the same processes for prescribing and administering all classes of drugs in this category apply. For example, a determination is made about the resident's need for the drug, appropriate dosing of the drug is made relative to the patient's characteristics, alternative treatments are explored, assessment is performed to determine the effectiveness of the drug and continued need for the medication is evaluated through medication monitoring. These requirements are found at Joint Commission standards TX.4.1, TX.4.12.1, TX 4.12.2, and TX.4.12.3.

The Joint Commission does not separate out antipsychotic drugs, or any of the other classes of psychotropic medications, because appropriate use and monitoring of all psychotropic drugs is important. HCFA appears to be directing their surveyors to focus on antipsychotics in order to ensure that residents on these medications have had a comprehensive assessment of their therapeutic needs performed, have appropriate

diagnostic information included in their record, and have been placed under a monitoring program that reduces their need for antipsychotics as soon as possible. However, the Joint Commission takes the position that all residents on any pharmacologic agent in the psychotropic category should have these protections, and the Joint Commission would be uncomfortable with a survey process that highlighted just one class of these agents.

Finding #2. *The Joint Commission standards are heavily weighted towards structure and process.*

This is a misinformed and misguided statement. Joint Commission standards are patient-centered. Many of the Joint Commission standards are written and organized from the perspective of what is important to patients in terms of their outcomes. For example, patients/residents want to know:

- "Can I get care if I need it?" - answered by the JCAHO standards on access to care and services.
- "Can they figure out what is wrong with me?" - the JCAHO Assessment of Residents standards.
- "Do they tell me what's wrong with me and what I can do to get well?" - the JCAHO Education of Residents standards.
- "Do they know what to do to help me?" - JCAHO Care and Treatment of Residents standards.
- "Are all my care givers working together to help me?" - The JCAHO standards on integration of services.
- "Can they take care of me, no matter how sick I get?" - The JCAHO Care and Treatment of Residents standards.
- "Do they respect me as a person?" - The JCAHO Resident Rights and Organization Ethics standards.

The Joint Commission accreditation standards are patient-focused and concerned with patient outcomes that include clinical, functional, quality of life, and patient satisfaction. While it is critical to evaluate such results, one must not lose sight of the fact that the way an organization achieves good outcomes is by designing and controlling its own processes well. The Joint Commission's approach is to look at overall performance -- whether an organization is using appropriate processes to optimize good outcomes, and achieving expectations. The Joint Commission requires that organizations measure their outcomes of care and services. Further, the Joint Commission verifies that organizations are using credible evaluative information to constantly improve its performance.

The JCAHO standards pose three types of questions; Is the organization doing the right things?; Is it doing them well?; and Is the organization improving? The standards are not static -- periodic revisions reflect new developments in health care delivery and new methods of evaluation. Further, the above queries about performance are applicable to a dynamic nursing home population, a significant advantage over HCFA standards which were based upon a 1986 resident population. Today's average Medicare nursing home resident is more acute than in 1986, receives more services and more sophisticated treatment. The Joint Commission standards are relevant to these population dynamics. HCFA nursing home standards are still based on the Institute of Medicine report from the 1980's, while Joint Commission standards have been updated continually since that time. The Joint Commission evaluates its standards annually, and receives advice from a broad array of long term care experts, measurement experts, purchasers, and consumers each year in order to ensure a state-of-the-art product.

As a mandatory part of the accreditation process, nursing homes must begin reporting performance measurement information to the Joint Commission on a quarterly basis. This requirement began in 1997 and is called ORYX. The goal of ORYX is to create a more continuous, data-driven, comprehensive and valuable accreditation process -- one which not only evaluates a health care organization's methods of doing the right things (standards compliance), but the outcomes of these methods as well. In addition to supplementing standards-based information for external monitoring of facility performance, these data submissions will eventually by used to validate the correlation between standards and outcomes of care. HCFA has not yet implemented measurement requirements for its long term care programs, although they are now mandating the reporting of Minimum Data Set information on each nursing home resident.

Moreover, these performance measures collected as part of ORYX requirements will supplement and guide the standards-based survey process by providing a more targeted basis for the regular accreditation survey; a basis for continuously monitoring actual performance; and a basis for guiding and stimulating continuous improvement in health care organizations.

It is noteworthy that despite today's keen interest in measuring outcomes, outcomes by nature are always evidence of past performance: they are the results of the processes used to get to that point. An evaluator must ask, even if the outcomes appear to be good, "Is this organization able to maintain these outcomes and improve on them?" So, whether you're looking at standards or outcomes you're looking at processes which led to those outcomes. You can't look only at outcomes and expect to get the whole picture.

Finding #3. *Joint Commission surveys do not collect sufficient information to assure compliance with Medicare requirements. Generally, observations of resident care were not a priority.*

The Abt Associates conclusions on the Joint Commission survey process are based on observation of four surveys. The results of these surveys were not compared to HCFA surveys to determine if the Joint Commission process was as effective as the Medicare process in assessing quality in these four organizations.

Furthermore, the researchers did not understand how the Joint Commission surveyors collect information. Rather, they assumed that the HCFA methodology is the only way to assure that the survey findings contain an adequate focus on resident care.

The Joint Commission long term care survey is evaluative, consultative and educational. Information is collected through observation, interviews with residents and staff, and document reviews. The survey:

- measures the organization against objective, state-of-the-art standards;
- promotes performance improvement; and
- makes available a Public Information Interview for interested residents, families, staff and the community.

During the on-site evaluative reviews, surveyors look at key performance areas such as: resident rights and organization functions, continuum of care, assessment of residents, care and treatment of residents, education of residents, improving organization performance, leadership, surveillance, prevention and control of infection, management of human resources, management of information, and management of the environment of care. In all, Joint Commission surveyors, who are experts in their fields, look at a long term care organization's compliance with more than 500 performance-based standards in 35 performance areas.

This is another area of comparison where the Joint Commission's input would have assisted in achieving a valid comparison. It would have been particularly important here, because there are differing philosophies between the Joint Commission and HCFA on how to observe care being delivered during a survey. For example, HCFA will follow a nurse around and watch how he/she administers medication. The Joint Commission takes a systems approach. The Joint Commission surveyor first reviews the nurse's

credentials, then looks at medical records to learn if there were any problems with medication administration. Next, the surveyor tours the facility and interviews patients and staff. In this manner, a great deal of information about medication administration is acquired. The Joint Commission surveyor is specifically trained to observe care processes unobtrusively, while performing other tasks and without putting undue attention on a single nurse under the spotlight, or unnecessarily impinging upon patient privacy.

As mentioned earlier, Abt Associates neglected to look at the Joint Commission's *Guide to the Survey Process.* For example, pages 81-82 list some specific questions the surveyor can ask residents about the care they receive, such as: "Have you been encouraged to become involved in all aspects of your care?" -- "Do you feel that your rights to independent expression, considerate treatment, personal freedom, etc. are respected and supported? -- "Are you able to have visitors when you like?."

Finding #4. *HCFA's survey system is more stringent in defining steps to be taken to correct deficiencies.*

HCFA's system is different, but not more effective. In addition to the very thorough review provided during the survey, the Joint Commission has a variety of ways of monitoring an organization's performance between surveys. As mentioned above, the Joint Commission's philosophy for achieving organizational change and improvement differs from that of governmental enforcement programs. Specifically, the HCFA enforcement process is focused on assuring that a nursing home meets all of the Medicare requirements at a specific snapshot in time. Substantive deviations from the regulations represent a "black mark," and must be corrected in regulatorily prescribed time periods. In contrast, the Joint Commission is focused on achieving sustained correction of problems and improving the care in its accredited facilities. The Joint Commission surveyor is trained to assist the nursing home in understanding what they must do to achieve optimal quality of care. Deficiencies are documented, and plans of correction are required, but the underlying stress is on implementing systems changes that will be long lasting and effective into the future. HCFA process doe not offer any consultation or assist facilities with systemic changes. Therefore, nursing homes are less likely to understand how to modify their processes to avoid future deficiencies. As a result, any correction of deficiencies has been shown to be temporary, as borne out by HCFA's own data.

- Organizations that are accredited with recommendations for improvement are required to bring the cited areas into compliance with the standards within specified time frames. Progress of these organizations is checked on through a follow-up visit called a focus survey or through a written progress report.
- Even without the requirements of a deemed status relationship, each year JCAHO selects for random, unannounced surveys 5 percent of all accredited organizations that are at the midpoint of their survey cycle. To validate JCAHO processes, specially trained surveyors visit these organizations and review areas identified as being problematic for a large percentage of organizations.
- The Joint Commission conducts other unannounced surveys in response to serious incidents related to the health and/or safety of patients or staff, or complaints.
- The Joint Commission's Sentinel Event Policy requires the completion of a comprehensive, detailed root cause analysis on all serious, adverse events. There are specific time frames attached to the process for reporting, analyzing the problem and taking corrective action.
- The Joint Commission responds to complaints received about accredited organizations. Complaints may be forwarded by state licensing agencies, family, staff, or come directly from consumers, payers or health care professionals. The Joint Commission addresses all complaints that pertain to quality of care issues within the scope of our standards.

It must be remembered that the Joint Commission long term care survey is not an enforcement survey. As in other Joint Commission accreditation programs where deeming exists, revisions to the survey process and follow up procedures are instituted when deeming is established. In this manner, Medicare specific issues are recognized and respected, while maintaining the quality improvement focus of an accreditation survey.

Finding #5. *Joint Commission surveyors seem to miss serious deficiencies.*

As evidence of the statement, HCFA states that in 7 percent of the cohort of 179 matched nursing home surveys, "HCFA found facilities providing substandard quality of care and (causing) actual harm to residents. JCAHO reported no such problems in these facilities..." Not only is this statement not supported by a review of the same data used in this study, but ***we found that what HCFA didn't say is that:***

- o The conclusions derived from the data were distorted by the failure to consider perhaps the most important confounding variable when drawing

inferences from the review -- that is, whose survey team went into the nursing home first! We found that HCFA failed to factor out of the seven percent, those instances where HCFA went in before the Joint Commission, and the particular problems found by HCFA should have already been corrected by the facility. Therefore, the Joint Commission would have **NOT** found the same problems, unless HCFA's enforcement process had failed. This is a serious methodological error in presenting the conclusions.

- When evaluating the 34 nursing homes in the study that were found by either HCFA or the Joint Commission to have significant quality of care issues, Joint Commission surveyors tended to find more quality of care issues, with broader scope, than were identified by HCFA.

- Notwithstanding the above, there was a high level of agreement between JCAHO and HCFA on finding similar issues in the entire cohort of 179 nursing homes, despite differences in how deficiencies are categorized on the survey report form.

- In terms of "ability to take action," only the Joint Commission denied participation to any of the study's nursing homes. The Joint Commission removed accreditation from a nursing home that HCFA considered as acceptable for continued Medicare certification.

- In nine of the ten facilities in the study given the most severe ratings by HCFA (a scope and severity score of "H" or above), the Joint Commission found additional serious deficiencies that were not cited by HCFA.

- There were four nursing homes where the Joint Commission found significant findings that were overlooked by the HCFA surveyors.

- There was both inconsistency and significant issues of judgment surrounding what HCFA rated as serious harm to residents.

- In the majority of cases where HCFA went in before the Joint Commission, the Joint Commission tended to find more and more severe problems than when it was the first reviewer. This casts doubt on the capability of HCFA to effect changes on a comprehensive set of quality problems.

- Differences in how the Joint Commission and HCFA cite deficiencies was not taken into account. In many of the seven percent, despite Joint Commission being the second team in, similar findings were made by the Joint Commission, but expressed differently. For example, in some of the cases, HCFA cited a failure of the facility to complete MDS requirements. Because the Joint Commission does not have a deemed status relationship for nursing home surveys, a similar problem with completion of patient information can appear under a variety of citations; such as staff competency, patient assessment problems, documentation issues, etc. When these differences are taken into account, the seven percent evaporates.

Background information for the above response points

We asked HCFA and Abt Associates to identify the 12 instances in which they claim serious harm to patients occurred without a similar citation by the Joint Commission; i.e., the seven percent referenced in the report. Both Abt Associates and HCFA refused to identify these nursing homes to facilitate our analysis. Faced with a need to deduce which of the 179 sets of records comprised the 7 seven percent in order to properly respond, the Joint Commission selected all 27 nursing home surveys in the cohort that had been given any indication by HCFA of serious patient jeopardy (in HCFA terminology, any nursing home with a "G" or worse citation.) By definition, this would be the universe of nursing homes in which the 12 in question would reside.

Next, in an effort to determine which of these nursing homes were part of the seven percent, the Joint Commission reviewed all the findings from both HCFA and JCAHO relevant to the 27 cases. We could not replicate a seven percent finding where the Joint Commission failed to find similar quality problems as did HCFA.

In fact, since only 12 of these 27 cases are being questioned by HCFA, it its reasonable to conclude that a larger proportion (n= 15) are not. Further, of the cases which we deduced were the 12 in question, HCFA was the first surveyor the majority of the time -- , preceding the Joint Commission by enough weeks to have cited specific deficiencies and obtained correction of the problem before the Joint Commission conducted its survey. Therefore, for these situations, the Joint Commission should Not have found the same serious harm that HCFA cited in its survey findings. In fact, one would postulate that for all instances where HCFA was the first surveyor, there should not be any serious harm to patients found during a subsequent survey by the Joint

Commission, because HCFA's own rules require that those deficiencies be corrected. It is also reasonable to assume that a nursing home would place special emphasis on such corrections knowing that a second review body was scheduled to evaluate the facility shortly thereafter.

Moreover, the study neglected to provide information damaging to the HCFA survey process by pointing out that even when the Joint Commission went in after HCFA, -- and therefore should find considerably fewer problems in those particular facilities -- the JCAHO surveyors found a greater scope and severity of problems then when it went in first. The implications from this finding are that HCFA fails both to detect many problems and to enforce lasting corrections.

Finding #6. *Public access to Joint Commission survey findings are limited.*

This is patently untrue. For years, performance reports on accredited facilities have been made available to the public. Consumers can look up an organization's accreditation status on Quality Check™, located on the Joint Commission's Web site at www.jcaho.org. Quality Check provides a list of the more than 18,000 Joint Commission-accredited health care organizations and programs throughout the United States. The listing includes each organization's name, address, telephone number, accreditation decision, accreditation date, and current accreditation status and effective date. But even more importantly, the study neglects to state that when the Joint Commission enters into a deemed status relationship, HCFA can set the terms of how much information should be available. The Joint Commission made this point repeatedly to the study's research team. Because the Joint Commission is committed to public disclosure, any reasonable terms for additional reports to the public would be met.

For more in-depth quality information, consumers can check the individual performance reports available for a number of accredited organizations that were surveyed after January 1, 1996. Performance reports detail a health care facility's accreditation date and decision; the organization's overall performance level; its performance level for key areas -- such as patient rights, infection control, medication use, human resources planning; areas with recommendations for improvement, if applicable; and a display of how the individual organization compares to other organizations nationally in each performance area. This information is also available by calling the Joint Commission's Customer Service Center at 630-792-5800.

This commitment to public accountability is inherent in the Joint Commission's mission -- to improve the quality of care provided to the public through the provision of health care accreditation and related services that support performance improvement in health care organizations. This accountability is demonstrated in every aspect of the Joint Commission's operations -- from its governing board, to its standards and survey processes, to ensuring the public has access to valuable information about quality. The following examples highlight the Joint Commission's commitment to the public:

- The Joint Commission's 28-member Board of Commissioners includes six public members that represent the public's interests in the oversight of the Joint Commission.

- The dozens of advisory panels that develop Joint Commission standards and survey processes include representatives from consumer organizations, and federal and state governments to give the Joint Commission insight into public expectations for quality care.

- The Joint Commission is moving aggressively to increase the public's familiarity about accreditation and the information available to them.

  The Joint Commission's site on the World Wide Web provides consumers with information about a variety of topics, including accreditation status and actual performance reports.
  The Joint Commission provides by request free informational brochures to help consumers choose quality health care.
  Staff are working with *Health Pages* and *Consumer's CHECKBOOK* to improve access to organization-specific performance information.

- The Joint Commission makes available a Public Information Interview for interested residents, families, staff and the community.

- The Joint Commission responds to complaints received about accredited organizations. Complaints may be forwarded by HCFA, state licensing agencies, or come directly from consumers, payers or health care professionals.

Summary

We regret that an opportunity for a full and fair evaluation of the role that private sector accreditation could play in enhancing quality care for nursing home residents has been lost. Unfortunately, poor execution of the study methodology combined with political considerations resulted in a very biased report. Furthermore, a discussion in the Executive Summary of areas where private sector accreditation traditionally excels over governmental regulatory programs -- such as in factors related to cost; currency of standards; ability to respond quickly; and surveyor expertise, credentials, and training -- were omitted or dismissed.

The Joint Commission was always skeptical that an unbiased report could be written in light of HCFA's long standing and often articulated position against deemed status for nursing homes. However, we agreed to participate openly in order to share our knowledge and advance the dialogue about how best to improve the study of the quality of care in nursing homes.

The Joint Commission values its partnerships with HCFA and expects that when there is more time to thoroughly reflect on the content of the report -- in cooperation with the Joint Commission -- very different conclusions will be reached.

LOUISIANA ASSOCIATION OF HOMES & SERVICES FOR THE AGING
P.O. Box 14615 • Baton Rouge, Louisiana 70898

July 27, 1997

The Honorable John B. Breaux
United States Senate
Washington, DC 20510

Dear Senator Breaux:

I am writing to you as Ranking Member of the Special Aging Committee. On behalf of the Louisiana Association of Homes and Services for the Aging, I would like to share concerns regarding the Senate Special Aging Committee's hearing this week of findings by the General Accounting Office on the quality of care in California nursing facilities.

The report is more than disturbing. It appears that a number of California nursing homes have betrayed the public trust through gross neglect. Perhaps, equally or even more disturbing is the failure of appropriate California state agencies to monitor the performance of nursing facilities, and take corrective action. What our members have shared with us is that the state is undermanned. In one example, they could not produce a pharmacist and dietitican. Three three nurses were required to perform the entire inspection and during that time they were on the phone dealing with other issues. Enforcement efforts need to be better funded.

Since the early 1990's, federal law has granted the states, through their Medicaid survey agencies, expanded authority to prevent such abuses. **The state can close a facility.** It can take over the management of a facility. It can put "on-site" monitors in a facility. It can terminate government payment. It can levy monetary fines.

Abuses, such as those portrayed in this GAO report outrage those of us who have devoted our lives to the service of the frail elderly. The vast majority of employees of nursing facilities are conscientious, dedicated individuals for whom the care of the infirm is a labor of compassion and love.

The tragedy in California is not limited to the victims of poor care in California, but also extends to those aged everywhere who avoid seeking nursing facility services because of the stigma created by such homes. It infuriates us to witness truly egregious situations that continue year after year when the tools noted above exist to eradicate such abuses.

Phone (504)201-9933
Fax (504)201-9944

Affiliated with AAHSA
American Association of
Homes & Services for the Aging

The responsibility of government, howerever, goes beyond simply taking steps to correct abuses after-the-fact. It also is responsible for ensuring that its payment system contains the proper incentives to produce appropriate outcomes.

It is the height of hypocrisy for California and other states to pay a facility half of what it costs to provide services, and then be surprised that only half of needed services are provided. It is equally hypocritical to structure a system that permits a facility to retain any degree of "profit" it wants and then be surprised when it does so.

There are things that should be done to prevent problems from developing. Enforcement efforts should be focused on facilities with poor performance history, and less emphasis placed on perfection in areas not directly affecting patient care (perfection is difficult to achieve with human beings). The state should employ other predictors of potential problems such as absentee owners, frequent turnover of Administrators/Directors of Nursing and the excessive use of temporary staff. We should be using our limited enforcement dollars on repeat offenders!

We understand there are recommendations in the study and we are supportive of those. We support more random inspections, more stratified sampling of medical records for review, chronic poor performs must be fined and more revisits verifying corrections.

Not for-profit homes are mission-oriented; they exist only to serve the aging. They are a vital part of the community and ascribe to providing high quality care for those they have chosen to serve.

Thank you for the opportunity to comment on the General Accounting Office report. We hope you appreciate the fact that all nursing facilities are not bad providers; there are many good nursing facilities in Louisiana and around the country. If you have any questions, please call me at (504) 201-9933.

Sincerely,

Allison Gremillion

Allison Gremillion
Executive Director

Phone (504)201-9933
Fax (504)201-9944

LNHA
Louisiana Nursing Home Association

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Baton Rouge, Louisiana 70809
504 927-5642
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July 21, 1998

The Honorable John B. Breaux
United States Senate
516 Hart Senate Office Building
Washington, D.C. 20510

Dear Senator Breaux:

Thank you for this opportunity to give you a provider perspective and to enter comments for the planned hearings by the Senate Aging Committee to examine the General Accounting Office's report on alleged neglect in California nursing facilities. While providers, lawmakers and regulators often see different sides of issues, it can only benefit patient care when we overcome any differences and work together.

In reviewing my comments, please keep in mind that the report has not been released. It is difficult to address with any accuracy a general topic without having seen specific areas of concern.

First, it is my understanding that the actual GAO investigation involved only a minuscule number of nursing facilities (15) and a tiny sampling of residents (62). Only three facilities were actually visited by GAO. The GAO selected these facilities from the state's *poorest* performing nursing facilities.

In contrast, you may be interested in an independent study conducted by Louisiana State University, School of Human Ecology. This survey took 16 *randomly* selected nursing facilities which included chain and independent operations, for-profit and not-for-profit facilities, rural and urban facilities and small and large facilities. According to the principal investigator, Fran C. Lawrence, Ph.D., the study had a phenomenal response rate of 63% -- a much more complete sampling than the GAO study. This study found that 83% of the responsible parties were satisfied with the nursing facility -- 40% being very satisfied and 43% being satisfied.

As you know, nursing facilities are surveyed annually by state health agencies to determine if the nursing facility is in compliance with federal and state regulations. Deficient practices by nursing facilities are categorized into "numbered tags", judged according to the scope and severity of the violation, and reported by surveyors on Federal form 2567.

Only 5.31% of Louisiana nursing facilities are cited for deficient practices under the federal tag concerning nutrition. The national average is 9.31%. Of all deficient practices cited in Louisiana 68.36% are judged by the state agency as having no actual harm with potential for minimal harm. The national average is 25.72%. Only 4.13% of the cited violations are judged to have caused actual harm and only 0.18% of deficiencies are judged as causing immediate jeopardy. The national average is 13.37% and 0.31% respectively.

When our industry identifies topics that are of concern either nationally or statewide, we assemble task forces to address these issues. In Louisiana, our association has been on the

cutting edge of issues such as nurse aide training and certification. In 1987 LNHA implemented a Nurse Assistant Pilot Training Program, prior to Federal legislation mandating nurse assistant training. LNHA was among the first to push for criminal background check legislation for employees in nursing facilities. While we do not consider nutrition and hydration to be a problem in Louisiana, we recognize the significance of the GAO study and have addressed nutrition in the following ways: 1) written information to providers, and 2) educational sessions focusing on nutrition and hydration issues.

If you are searching for recommendations that would further enhance quality of care in nursing facilities, I would suggest that you support deemed status for facilities choosing to undergo a survey with the Joint Commission for the Accreditation of Healthcare Organizations. The Office of Management and Budget has required a study on the efficiency of deemed status in comparison to HCFA surveys. This study has been delayed.

This tool would serve to continue to improve the quality of care in nursing facilities because of the difference in the nature of the two surveys. The state conducts a negative, punitive survey. JCAHO looks at every aspect of a nursing facility operation. Its philosophy is if an area needs attention, JCAHO works with providers to address the problems. According to providers who have voluntarily undergone a JCAHO survey, the process is not inexpensive; it is not easy; it does, however, make significant contributions to quality care.

The most recent barrier to quality of care in nursing facilities is the repeal of the Boren Amendment. No longer must states reimburse facilities adequately for providing economical, quality care to patients. This year in Louisiana, the state has chosen not to adjust reimbursement for increases in the cost of living. If this continues, providers will not be able to provide quality of care.

In summary, documentation supports the fact that nutrition and hydration are not critical problems in Louisiana. If you are, however, seeking methods to enhance quality care in the state's nursing facilities, I would suggest the support of deemed status and some mechanism by which nursing facilities must be adequately paid for economically caring for nursing facility patients.

I hope my comments have given you insight into the nutrition and hydration issue in Louisiana. I appreciate the opportunity to share with you providers' perspectives on quality of care and hope to work with you and the Senate Aging Committee as this issue develops.

Sincerely,

Joseph A. Donchess

Joseph A. Donchess
Executive Director

enclosures
cc: Paul Willging
Bruce Yarwood
LNHA Executive Committee

Report can be found at the following website www.newszap.com/nhtoc.html



THE STATE LEGISLATIVE & CITIZENS INVESTIGATIVE PANEL

ON *NURSING HOME REFORM*

REPORT TO THE PEOPLE OF THE STATE OF DELAWARE

FEBRUARY 9, 1998

STATE LEGISLATIVE & CITIZENS INVESTIGATIVE PANEL ON NURSING HOME REFORM

1997-1998 ROSTER

1. Sen. Robert I. Marshall: Panel Chairman; Chair, Senate Labor & Industrial Relations Committee; Chair, Senate Revenue & Taxation Committee

2. Sen. Patricia M. Blevins: Chair, Senate Health & Social Services Committee

3. Rep. Pamela S. Maier: Chair, House Health & Human Development Committee

4. Rep. Vincent A. Lofink: Vice-Chair, House Land Use & Infrastructure Committee; Member, Joint Bond Bill Committee

5. Rep. Arthur Scott: Member, House Housing & Community Affairs Committee

6. Thomas Herlihy, III, Esq.: Wilmington attorney, emphasis on elder law; former chair, Delaware State Bar Association Committee on Law & the Elderly

7. Selma Hayman, Esq.: Certified Elder Law Attorney in Wilmington; vice-chair, D. S. B. A. Committee on Law & the Elderly; member, National Academy of Elder Law Attorneys; member, Board of Directors of Alzheimer's Association

8. Carolee Burton Kunz, Esq.: Supervising Attorney, The Elder Law Program of Community Legal Aid Society, Inc.

9. Pat Engelhardt: M. S., R. N.; patient advocate; Co-chair, Delaware Nurses Association-Legislative Division; Secretary, State Legislative Committee of AARP

10. Katherine Anderson: patient advocate with TRIAD of Dover area; member of AARP Continuing Care Task Force

11. Rose Bussard: R. N., C.; Skilled Unit Manager, Integrated Health Service of Smyrna; Vice-Chair of AARP State Legislative Committee

12. John Russo (Alternate): Chair of AARP State Legislative Committee

13. Elizabeth C. Miles: Certified Nursing Assistant

14. Phyllis Peavy: Patient advocate

Panel Staff: Stephen P. Tanzer, Administrative Assistant, Delaware State Senate Majority Caucus

Mission Statement

From its inception, the Legislative & Citizens Investigative Panel on Nursing Home Reform has adhered steadfastly to the following mission:

"The purpose of the Legislative & Citizens Investigative Panel on Nursing Home Reform is to ensure that residents of Delaware nursing homes are safe and secure, are receiving quality care, and are free from abuse, neglect and financial exploitation."

The Panel's activities have been undertaken with the intent of accomplishing this mission.

ACKNOWLEDGEMENTS

The State Legislative & Citizens Investigative Panel on Nursing Home Reform wishes to gratefully acknowledge the following:

Each and every person who contacted the Panel, testified at one of the Panel's hearings or in Executive Session, or provided written testimony to the Panel. Without their commitment and dedication to nursing home reform, the Panel's work would not have been possible.

Governor Thomas R. Carper and his staff for their assistance.

Dr. Gregg Sylvester, Secretary of the Department of Health & Social Services, and his staff for their assistance.

Attorney General M. Jane Brady and her staff for their assistance.

Richard R. Weir, Jr., Esq., for providing legal counsel to the Panel.

Senator Dorinda Connor and Senator Margaret Rose Henry for their invaluable participation and insight.

The following participants in the Panel's Roundtable Workshop of January 7, 1998: Carol Berster, Ingleside Homes; Lisa Blunt-Bradley,DHSS, Office of the Secretary; Steve Boedigheimer, Division of Public Health; Stephanie Brandt, Delaware Technical & Community College; Eleanor Cain, Director, Division of Aging and Services to Persons with Physical Disabilities; Thomas E. Carluccio, Deputy Attorney General, Medicaid Fraud Control Unit; David L. Carman, Department of Justice, Medicaid Fraud Control Unit; Senator Dori Connor; Senator Nancy Cook; John Frazer, III, Office of the Controller General; Senator Margaret Rose Henry; Bob Lawson, Delaware Health Care Facilities Association; Joseph M. Letnaunchyn, Delaware Healthcare Association; Chris Long, DHSS; Mary McDonough, DHSS, Office of the Secretary; Jean Raymond, University of Delaware, Instructor, Department of Nursing; Ellen Reap, DHSS, Director-Office of Health Facilities Licensing & Certification; Michael J. Rich, State Solicitor; William Rolleri, Alzheimer's Association of Delaware, Chair-Public Policy Committee; Liz Ryan, Office of the Governor; Phil Soule, Sr., DHSS, Medicaid Office; Dr. Gregg C. Sylvester, Secretary, DHSS; Bruce Thevenot, Genesis Health Ventures, Inc.; Tom Wagner, State Auditor; Irene Waldron; Cheryl T. Weidemeyer, Alzheimer's Association of Delaware; Janet West, New Castle County Vocational-Technical School District; Ann Woolfolk, Deputy Attorney General.

Cheryl T. Weidemeyer of the Alzheimer's Association of Delaware and Lisa Oleson for their work in helping the Panel to frame its recommendations.

Maribel Ruiz of the Office of Wilmington City Clerk for her assistance in securing the use of the Council Chamber of the City/County Building.

The following people who assisted the Panel in its development of recommendations pertaining to staff development and training:

Sue Ackley, Nurse Practitioner, Health Center, Newark Senior Center; Gloria Green, R. N., CNA Instructor, Delaware Technical & Community College; Donna Racine, Peninsula United Methodist Homes, Long-Term Care Council-Delaware Nurses Association; Jean Raymond, R. N., Instructor-University of Delaware; Cheryl T. Weidemeyer, R. N., Evergreen Adult Day Care; Janet West, R. N., Director-L.P.N. Program, Delcastle High School/Delaware Skills Center; Cathy Williamson, R. N., CNA Instructor-Howard Vocational-Technical High School.

History and Activities of the Legislative and Citizens Investigative Panel on Nursing Home Reform

On Monday, September 29, 1997, Senator Robert I. Marshall convened a press conference and announced the formation of the State Legislative and Citizens Investigative Panel on Nursing Home Reform. The press conference took place at the Claymore Senior Center at 504 S. Clayton Street in Wilmington.

The creation of the Panel marked the beginning of the first comprehensive investigation into Delaware nursing home practices since the 1960's.

At the press conference, Senator Marshall stated that the creation of the Panel was "in response to an overwhelming number of citizen complaints we in the General Assembly have received from constituents with real concerns about the safety and well-being of their loved ones" in Delaware nursing homes.

Senator Marshall pledged that the Panel's investigation would examine every relevant issue, including licensing, state laws and regulations, funding, training, staffing, quality of care, and personal safety.

At the press conference, Senator Marshall announced that the Panel would hold three public hearings throughout the state to receive testimony from concerned citizens. Due to overwhelming public interest, an additional public hearing was subsequently added. The hearings took place at the following times and locations:

Wednesday, October 15, 1997, 7 p.m., Sussex County Council Chambers, Georgetown.

Wednesday, October 22, 1997, 7 p.m., Kent County Levy Court Chamber, Dover.

Monday, October 27, 1997, 7 p.m., Delaware Technical & Community College, Stanton Campus, Newark.

Thursday, October 30, 1997, 6 p.m., City/County Building, Wilmington.

In response to the announcement of the public hearings, over 300 people contacted the Investigative Panel. 62 witnesses testified at the public hearings. An additional 35 people submitted written testimony. Six people testified before the Panel in executive sessions.

Following the public hearings, the Panel conducted public reviews of the state agencies charged with nursing home oversight and regulation. Agencies were invited to make presentations to the Panel concerning their responsibilities for nursing home oversight and regulation. Agencies were also requested to provide recommendations for improving their ability to protect residents of nursing home beds from abuse, neglect and financial exploitation. Question-and-answer sessions followed the presentations.

All agency reviews took place at the City/County Council Chambers in Wilmington on the following dates and times:

Wednesday, November 19, 1997:	2 p.m.: Office of Health Facilities Licensing & Certification
	4 p.m.: Division of Public Health
Monday, November 24, 1997:	3 p.m.: Office of the Attorney General
Wednesday, December 3, 1997:	3 p.m.: Division of Aging
	5 p.m.: Office of the Long-Term Care Ombudsman
	7 p.m.: Division of Social Services-Medicaid Office.

The Panel then concluded the Public Hearing phase of its work by conducting a hearing on the nursing home industry on Wednesday, December 10, 1997 at the City/County Building in Wilmington. Representatives of the nursing home industry addressed the panel concerning nursing home care in Delaware and presented recommendations as to how the current regulatory system should be changed to ensure that residents of Delaware nursing homes are provided quality care and service.

Five witnesses testified at this hearing, including representatives of all 51 nursing homes in the state.

The Panel then convened a Roundtable Workshop on Wednesday, January 7, 1998 at the Buena Vista Conference Center.

Over 40 persons, including policymakers from the Governor's Office, the Department of Justice, the Department of Health & Social Services, the State Auditor's Office, representatives from the nursing home industry, and the Investigative Panel, participated in the daylong discussions.

The format of the roundtable consisted of the Panel identifying specific areas and issues for discussion followed by open dialogue on the identified issues. As a result of these discussions and the remainder of the Panel's work, the Panel developed findings and recommendations for each of the following areas of policy review:

Creation of a Division of Long-Term Care

Office of the Long-Term Care Ombudsman

Appeals Process and Advisory Boards

Nursing Home Employee Training & Development

Code of Ethics and Public Disclosure

Office of the Attorney General

Nursing Home Economic Issues & Interests

Quality of Care.

The remainder of this report will center on the Panel's findings and recommendations for each of these topics.

Creation of a Division of Long-Term Care

Findings:

During its public hearings and subsequent deliberations, the Panel discovered that the single greatest impediment to effective nursing home regulation and oversight in Delaware is the failure of the various agencies charged with responsibilities for such regulation and oversight to effectively coordinate and communicate with each other.

In large part, the Office of the Long-Term Care Ombudsman, the Office of Health Facilities Licensing and Certification, the Medicaid Office of the Division of Social Services, and the Medicaid Fraud Unit in the Office of the Attorney General each operate in their own cocoons and fail to work in concert with each other.

The Panel finds that, unless and until this ineffective and counterproductive system is replaced with a system of effective coordination and communication among and between the various regulatory agencies, nursing home regulation in Delaware is doomed to be fragmented and ineffective.

Recommendations:

Accordingly, the Panel makes the following recommendation its highest priority:

1. The Panel recommends that a Division of Long-Term Care be established under the auspices of the Department of Health & Social Services, and that those personnel charged with nursing home regulation from the following agencies be housed in a common location:

The Office of the Long-Term Care Ombudsman

The Office of Health Facilities Licensing & Certification

The Medicaid Fraud Unit of the Office of the Attorney General

Members of the Civil Division of the Office of Attorney General

The Medicaid Office of the Division of Social Services.

2. The Panel also recommends that computer services and programs for the Division of Long-Term Care be coordinated so that the different agencies comprising the Division can create a centralized data base for efficient coordination.

The Panel wishes to emphasize that employees from the Office of Attorney General will continue to fall under the purview of the Attorney General, and will not be employees of the Division. Their physical location in the Division's offices will facilitate more timely interventions into criminal and civil matters, will permit more effective training of investigators for all affected agencies, and will help to ensure more effective prosecutions of serious nursing home violations.

3. The Panel recommends that, upon creation of this Division, common space be sought in the City/County Building in the City of Wilmington. Satellite offices in Kent and Sussex Counties will continue to house employees with downstate responsibilities.

The Panel has already requested that the New Castle County Executive Office reserve or encumber space to accommodate the needs of the Division of Long-Term Care in the City/County Building. Space has become available in this building due to the move of many County offices to other locations.

Office of the Long -Term -Care Ombudsman

Findings:

1. The Panel finds that the Office of Long-Term Care Ombudsman and the Division of Aging have failed in their responsibilities to make sure that the Office complies with its federal and state statutory responsibilities. Despite the efforts of some dedicated employees, the Office is, by its own admission, substantially out of compliance with the federal Older Americans Act. The Panel finds that this lack of compliance extends to the Office's state mandates as well.

2. The Panel finds that lack of adequate staffing, lack of administrative leadership, and the lack of an automated information system are key factors in the current shortcomings of the Office.

3. The Panel finds that the lack of early intervention into the complaints process by the Department of Justice makes it difficult for the Office to achieve satisfactory resolutions of complaints concerning abuse or neglect.

4. The Panel finds that there is a lack of sufficient follow-up and there is usually no written follow-up on complaints to residents and families of residents.

5. The Panel finds that there is insufficient outreach on the part of the Office to encourage residents and their families to file complaints or concerns with the Office.

6. The Panel finds that the hiring requirements for ombudspersons are not sufficient to ensure that investigations are handled professionally.

7. The Panel finds that there is a serious lack of coordination between the Office and all other state agencies charged with nursing home regulation, including the Office of Health Facilities Licensing & Certification, the Division of Social Services Medicaid Office, and the Department of Justice. The Panel finds that this systemic lack of coordination and communication is one of the key failings of the current system of nursing home regulation in the State of Delaware.

8. The Panel finds that the Office lacks a standard form for nursing homes to use when reporting incidents. This leads to nursing homes submitting copious quantities of paperwork with little relevance to the actual incident.

Recommendations:

1. The Panel recommends that the Office be reorganized in a way to bring said Office into compliance with all applicable state and Federal statutes. At the minimum, the Panel recommends that a statewide manager be authorized by the Joint Finance Committee and hired for the Office. The manager's initial responsibilities will include restoring order and structure to the Office and implementing systems and reforms that will bring the Office back into compliance with state and federal law. The Panel further recommends that the Office report to the General Assembly by May 1, 1998 as to the steps it has taken to bring it back into compliance with all Federal and state statutes.

2. The Panel recommends that the Office of Long-Term Care Ombudsman develop an automated information system that will provide for a case management tracking system; that will permit the Office to identify complaints by type and by facility; that will provide ombudspersons with lap-top computers enabling them to write reports directly from the facility rather than requiring them to return to their office to file their reports; and that will facilitate the quarterly public filing of reports detailing, at the minimum, types of complaints and verified complaints by type and facility. The Panel also recommends that this system be compatible with systems currently in use or being developed for use by the other agencies with nursing home regulatory responsibilities in order to create a centralized data base.

3. The Panel recommends that the Joint Finance Committee approve the funding request of the Department of Health & Social Services for seven additional positions for the Office of the Long-Term Care Ombudsman. The new positions would provide for one Statewide Manager, one Downstate Supervisor, one Administrative Assistant to organize the clerical functions of the Office and to administer the Adult Abuse Registry, and four ombudspersons. The Panel also recommends that the Joint Finance Committee approve the Department's request for $30,000 in contract fees to provide for a Fair Hearing Officer to hear appeals of those placed on the Adult Abuse Registry.

4. The Panel recommends that the job description for ombudspersons be rewritten to require either an investigative background and/or a medical or health-related background relevant to the work of the office.

5. The Panel recommends that the Office, in conjunction with the aforementioned case-tracking system, provide a written response to nursing home residents and families who file complaints and that that response provide a documentation of how the case was handled, as well as the outcome.

6. The Panel recommends that, in anticipation of the adoption of civil fines for violations that do not reach the level of criminality, the Office implement a system of referring prospective criminal cases to the Department of Justice while referring prospective civil actions to the Office of Health Facilities Licensing & Certification.

7. The Panel recommends that state-owned locked boxes be installed in accessible locations in all Delaware nursing homes to facilitate the submission of complaints, concerns and suggestions to the Office. The Panel also recommends that the phone number and contact information for the Office be prominently displayed in every nursing home room in the state.

8. The Panel recommends that legislation be enacted which would make intentional false reporting of activity by a nursing home employee a sanctionable offense.

9. The Panel recommends that the Office develop a standard incident reporting form for nursing homes designed to get all vital and pertinent information on an incident while eliminating the submission of peripheral paperwork.

10. The Panel recommends that the Department of Health & Social Services examine the feasibility of assigning ombudspersons based on specialized expertise of the ombudsperson rather than making an ombudsperson responsible for a specific group of nursing homes, as is the current practice.

Appeals Process and Advisory Boards

Findings:

1. The Panel finds that the current appeals process of the nursing home industry needs to be revised to ensure that the public has confidence in the process.

Any new process must fairly consider the interests and concerns of the residents, the residents' families, the providers, and the regulators.

The current system also has conflicts of interest. For example, the Division of Public Health has the dual responsibility of operating state-run nursing homes while regulating the exact same facilities. This existing system can clearly undermine public confidence in the independence of the regulators.

2. The Panel finds that a high-level and active advisory group would serve the public's interest by bringing ideas and suggestions to the Division of Long-Term Care.

Recommendations:

1. The Panel recommends that the Department of Health & Social Services develop and formalize a mechanism for handling appeals. The new appeals authority would have the following responsibilities:

a. To hear and adjudicate issues raised for review by persons aggrieved of an administrative action, including, but not limited to: (1) administrative findings of civil violations of, and enforcement of, regulations; (2) civil violations of, and enforcement of, resident rights; (3) civil lack of, or abuse of, care; and (4) the imposition, or lack of imposition, of penalties, such as civil fines, and the suspension or cancellation of licenses.

b. To review the refusal or granting of licenses.

c. To compel the attendance of witnesses and the production of documents by subpoena or other authority.

The following persons in the long-term care industry and its regulation would have standing to bring matters before this authority:

*** persons in the industry such as owners, operators, or employees**
***residents of such facilities**
*** families of the residents**
***the regulators and enforcers**
***the ombudsman**

*advocates for such persons.

2. The Panel recommends that the Governor's Advisory Council on Long-Term Care Facilities and the Advisory Council on Aging and Adults With Physical Disabilities be terminated, and that a a new Advisory Council on Long-Term Care be created under the new Division of Long-Term Care. The Panel further recommends that appointees to this high-level Council be citizens with a demonstrated interest and expertise in long-term care issues.

Nursing Home Employment Training and Development

Findings:

1. The Panel finds that Certified Nursing Assistants (CNAs) are the primary caregivers in most nursing homes, and that the nursing home industry has generally failed to adequately attract, retain, train, educate and remunerate CNAs. The Panel also finds that staffing ratios of CNAs to patients are generally inadequate to provide sufficient care to nursing home residents.

2. The Panel finds that the current standard of 75 hours of training for CNA Certification in Delaware is insufficient to ensure that CNAs are adequately prepared for the responsibilities of the job.

3. The panel finds that malnutrition is the single greatest cause of neglect complaints against nursing homes and that more training in nutrition would reduce this problem significantly.

Recommendations:

1. The Panel recommends that the minimum standard for certification of Certified Nursing Assistants be increased from the current 75 hours to a minimum standard of 120 hours.

2. The Panel recommends that a career ladder be developed for Certified Nursing Assistants consisting of at least the following three levels:

a. Intern

b. Team Member-based upon length of time employed- would result in increased pay

c. Team Leader/Preceptor-requires additional education-would result in increased pay.

3. The Panel recommends that the Board of Nursing be assigned the responsibility for certification of CNAs as well as certification of advanced education leading to promotion on the career ladder. The Panel recommends that the Board of Nursing be provided with one additional position to handle this responsibility. This could be a new position or could be a position transferred from

the Office of Health Facilities Licensing & Certification, which currently handles CNA Certification.

4. The Panel recommends that, as part of their basic 120 hours of training, all CNAs receive in-depth training on the techniques of feeding, feeding problems, hydration, malnutrition and its effects on healing, the importance of a calm and pleasant eating environment, the basics of nutrition, and cleanliness.

5. The Panel recommends, based upon the increased training that CNAs will receive, the current difficulties that nursing homes experience in retaining qualified CNAs, and the shamefully-low wages that many nursing homes pay for CNAs, that nursing homes accept their responsibility to pay CNAs a living wage commensurate with their responsibilities. An enlightened approach to remunerating CNAs would surely lead to greater retention and more effective recruitment of CNAs. The quality of resident health care will surely improve with the implementation of this recommendation.

6. The Panel recommends that the Department of Health & Social Services, through regulation, require that CNAs undergo two weeks of orientation when first hired at any nursing home.

7. The Panel recommends that a working group on curriculum be convened to develop the CNA curriculum and standards. This group is also charged with developing a Model for a Nursing Home Training Center for CNAs. This group will include members of the Panel, a nursing home director, a head nurse, a CNA, educators, and a representative of the Office of Health Facilities Licensing & Certification. This working group shall provide a preliminary report to the Panel by June 1, 1998.

Code of Ethics and Public Disclosure

Findings:

1. The Panel finds that it is essential that no state employee directly or indirectly charged with nursing home oversight engage in behavior that could be construed as being a conflict-of-interest with regard to their responsibility to regulate the nursing home industry.

2. The Panel finds that consumers of nursing home services have the right to know of financial interests that nursing homes have with other service providers, such as pharmacy services and physical therapy organizations.

Recommendations:

1. The Panel recommends that the Department of Health & Social Services (DHSS) and the Department of Justice conduct workshops for their employees who have nursing home oversight responsibilities in order to apprise them of their obligations under the state ethics guidelines.

2. The Panel recommends that DHSS and the Department of Justice develop a new public disclosure form which would document potential incidents of non-financial conflicts-of-interest. This form should be mandated through an Executive Order of the Governor.

3. The Panel recommends that legislation be drafted to clarify that nursing home facilities have an obligation to disclose to residents their relationships with providers of other nursing home services such as pharmacy, rehabilitation services, medical suppliers and any other services. This statutory change should be incorporated into Title 16, Delaware Code, S. 1121 (9).

Office of the Attorney General/Statutory Issues

Findings:

1. The Panel finds that the current threshold of requiring intentionality as a prerequisite of prosecution under Delaware's Physical Abuse statute in Title 16, Sections 1131 & 1136, makes abuse prosecutions extemely difficult due to the standard of proof.

2. The Panel finds that the Office of Attorney General often does not intervene in a timely manner when abuse or neglect are suspected by the Office of Long-Term Care Ombudsman.

3. The Panel finds that a lack of mandatory criminal background checks and pre-employment drug screenings make it difficult for authorities to prevent dangerous individuals from finding employment with nursing homes in proximity to vulnerable patients.

Recommendations:

1. The Panel recommends that the Patient/Resident Abuse Statutes be amended to eliminate an intentional act as a requirement for prosecution. The standard should reflect acts done knowingly or recklessly as defined by statute.

2. The Panel recommends that the Joint Finance Committee provide funding for two additional elder abuse investigators, one additional prosecutor, and a secretary in the Medicaid Fraud Unit to enable the Department of Justice to intervene in a timely manner on suspected cases of abuse, neglect, or financial exploitation. The Panel recommends the Attorney General formally dedicate these positions to work on the aforementioned cases, and these positions be in addition to those already working on cases involving abuse, neglect, or financial exploitation. The State of Delaware would be responsible for 25% of the costs for these positions with the remaining 75% funded through the Federal government's Medicaid Fraud program. Under current law, this ratio remains constant and is not subject to a progressively greater percentage of funding being required of the State in subsequent years.

3. The Panel recommends that the Joint Finance Committee provide funding for two additional attorneys and a paralegal for the Civil Division of the Department of Justice to provide adequate staffing to support the administration of civil penalties on nursing homes.

4. The Panel recommends that legislation be enacted to include "Failure to Provide Adequate Staffing" under Section 1136 of Title 16, which lists violations, and to include "financial exploitation" to the list of prosecutable offenses under Sections 1131 and 1136.

5. The Panel recommends that legislation be enacted raising the misdemeanor violation of "failing to report a suspected violation" on the part of a nursing home administrator or board member violation to felony status.

6. The Panel recommends that legislation be enacted increasing the fine for operating a nursing home without a license to $10,000.

7. The Panel recommends that legislation be enacted requiring mandatory criminal background checks for any person offered employment by a nursing home. Nursing homes may hire these employees on a conditional basis pending the outcome of the background check. In addition, the Panel recommends that said legislation also require mandatory pre-employment drug screening as a condition for employment.

Nursing Home Economic Issues & Interests

Findings:

1. The Panel finds that certain consumer protections are lacking under existing law for both residents and family members. The Panel also finds that residents and family members have been required by some nursing homes to sign contracts that are unenforceable under Federal law.

2. The Panel finds that nursing homes must currently bear the burden of certain costs due to the lack of a timely adjustment of Medicaid reimbursement rates.

3. The Panel finds that potential and current residents of nursing homes who are eligible for Medicaid benefits have difficulty obtaining Medicaid beds because nursing homes are permitted to limit the number of Medicaid beds that are certified. The Panel further finds that the shortage of Medicaid beds restricts the ability of residents to select nursing homes based on the quality of care they provide, adds to state and Federal government expense because patients languish for an unduly long time in hospital beds. This practice is also detrimental to the health of residents who must be transferred to a new bed or to an alternate facility while undergoing medical treatment.

4. The Panel finds that the Delaware income cap for long-term care no longer serves a meaningful purpose because nursing home residents whose income exceeds the cap can readily qualify for Medicaid benefits by executing a Miller trust. The need for a Miller trust creates an unnecessary burden for residents' family, especially if they must seek guardianship in order to set up the trust.

Recommendations:

1. The Panel recommends that the General Assembly raise the income cap to 300% of SSI, thus reducing the number of Delaware residents requiring Miller trusts. The Panel also recommends that the income cap be eliminated if the Federal government grants the necessary waiver.

2. The Panel recommends that the Joint Finance Committee allocate funds to provide for a quarterly adjustment of Medicaid reimbursement rates to enable nursing homes to be fairly remunerated for services provided to Medicaid patients.

3. The Panel recommends that a model standardized admission contract be developed by the Department of Health & Social Services to be used in all Delaware nursing homes.

4. The Panel recommends that the Joint Finance Committee fund a budget line to provide for nursing home care for legal immigrants ineligible for Medicaid.

5. The Panel recommends that legislation be enacted prohibiting the practice of requiring third parties to personally guarantee payment of nursing home bills.

6. The Panel recommends that nursing homes be assessed the charges for additional inspections by regulators caused by said homes' repeated violations.

7. The Panel recommends that nursing homes be required to provide itemized monthly billing statements of all charges to nursing home residents and/or their families.

8. The Panel recommends that, if a nursing home facility has any Medicaid-certified beds, all beds in said facility available to the general nursing home population must be Medicaid-certified.

Quality of Care

Findings:

1. The Panel finds that some nursing homes are not consistently providing the minimum 2.5 hours of direct patient care as provided in nursing home regulation. The Panel finds that, even if nursing homes were providing this minimal standard, the level of care would still not adequately address the needs of many nursing home residents.

2. The Panel finds that some nursing home facilities are now advertising special care units for patients with dementia and offer specialized services to patients who have experienced strokes and patients with special needs even though there are no specific rules and regulations governing these services.

3. The Panel finds that the Office of Health Facilities Licensing and Certification places far too great an emphasis on issues of "paperwork compliance" in its inspections and does not sufficiently focus its inspections on the health care being provided to the residents in the beds. The Panel also finds that this Office does not sufficiently emphasize "accident and mishandling" prevention and technical assistance to the facilities in addition to its current prioritization of enforcement and sanctions. According to records made available to the Panel, there were 1100 documented cases of injury caused by accident or mishandling in Delaware nursing homes in 1996. The Panel finds this number to be deplorable.

4. The Panel finds that the quality of medical and dental care in nursing homes is inconsistent and inadequate.

5. The Panel finds that nursing homes currently find that it costs less to be out of compliance than to be in compliance with statutes and regulations due to the absence of available financial sanctions. Under the current system, the lack of effective sanctions creates more of an incentive for nursing homes to be out of compliance with statutes and regulations governing nursing homes.

6. The Panel finds that Delawareans are not receiving adequate information to make informed choices when selecting long-term nursing care.

Recommendations:

1. The Panel recommends that the Secretary of the Department of Health & Social Services and the Chairman of this Panel name a working group of Panel members, state regulators and other interested parties to develop a revised standard of direct care. This panel should consider all viable alternatives including increasing the current minimal standards and devising a standard based upon the

specifie needs of nursing home residents. Any standard ultimately developed, however, must be an enforceable standard and not simply a goal. The Panel recommends that this working group report back to the Panel by April 15, 1998.

2. The Panel recommends that legislation be enacted creating an escalating series of fines to nursing homes for civil violations of their mandated responsibilities. This list of fines would ultimately result in stronger sanctions, such as license suspension or revocation upon reaching a critical threshold. The goal of this system is to make non-compliance more expensive than compliance.

3. The Panel recommends that the Secretary of the Department of Health & Social Services develop rules and regulations to govern the operations of Alzheimer's units and other special care nursing home units. The Panel further recommends that input from organizations representing these special needs patients be systemically included in the development of the rules and regulations.

4. The Panel recommends that the Secretary of the Department of Health & Social Services develop rules and regulations to govern the care of pediatric residents in Delaware nursing homes.

5. The Panel recommends that the Department of Health & Social Services develop and implement an aggressive prevention program to reduce accidents and mishandlings of nursing home residents.

6. The Panel recommends that the Department of Health & Social Services provide technical assistance to nursing homes to facilitate nursing home compliance with applicable laws and regulations.

7. The Panel recommends that the Office of Health Facilities Licensing & Certification make its annual and surprise inspections more "patient-focused". As part of this recommendation, the Panel calls for the Office to increase the number of patient medical records it reviews and calls for the Office to increase the number of patient and family interviews it conducts.

8. The Panel calls for the Office to conduct scheduled public meetings at the nursing homes for residents and their families after the release of their report and after the nursing home has crafted its response and/or plan of correction.

9. The Panel recommends that DHSS adopt a regulation requiring all nursing home employees to wear photo identification and name badges.

10. The Panel recommends that legislation be drafted requiring each nursing home to have an advanced practice nurse on staff in the event that a full-time physician is not on staff. A physician identified as a facility medical director does not constitute a full-time physician.

11. The Panel recommends that, due to the lack of dental services available in most nursing homes, the existing statute be changed to allow dental hygienists to provide dental services to nursing home residents under the supervision of the nursing home's medical director.

12. The Panel recommends that the Board of Dental Examiners review the current state of dental services in nursing homes and develop recommendations concerning improving the availability and quality of dental services to nursing home residents.

13. The Panel recommends that an annual consumer guide to Delaware nursing home care be developed by the Department of Health & Social Services. The Panel further recommends this guide include, at a minimum, the following for each and every nursing home: a report on the number and the nature of the deficiencies uncovered during annual and surprise inspections during the past year; and the number and nature of verified incidents as determined by the Office of Long-Term Care Ombudsman for the past three calendar years.

14. The Panel recommends that a regulation be developed requiring Nursing Home Activities Directors to be certified or eligible to be certified by the National Certification Council of Activities Professionals (NCCAP) when hired. Activities play a key role in the quality of life that residents enjoy, yet Delaware requires no demonstrated level of experience or competence for nursing home activities directors.

15. The Panel recommends that the Office of Health Facilities Licensing & Certification complete a review and revision of nursing home regulations in as timely a manner as possible. As part of its work, the Office is requested to consider all recommendations in this report that pertain to the regulations including, but not limited to, the Panel's request that unnecessary and redundant paperwork requirements be eliminated wherever possible. The Panel also requests that the revised regulations be written with clarity and precision so that nursing home administrators can have a reasonable understanding as to what is expected of them.

16. The Panel recommends that additional protections be included in the Patient's Bill of Rights (Title 16, Del. Code, S. 1121), and that a Quality of Care section be added to the rules and regulations governing nursing homes that mirrors Federal Quality of Care rules and regulations (Section 57.8). Specific recommended changes to the Patient's Bill of Rights are provided in Appendix A to this report.

17. The Panel recommends that the Joint Finance Committee fund two full-time Registered Nurse positions for the Office of Health Facilities Licensing & Certification. The two positions would be used to carry out surprise nursing home inspections.

APPENDIX A

16 *Del. C.* § 1121. Patient's Rights

(Added provisions are in **bold** and deletions are in brackets and *italics*.)

[*(1) Every patient and resident shall be treated with consideration, respect, and full recognition of the patient's or resident's dignity and individuality.*]

[*(2) Every patient and resident shall receive care, treatment and services which are adequate, appropriate, and in compliance with relevant federal and state laws and regulations.*]

(1) Every patient and resident shall have the right to receive considerate, respectful, and appropriate care, treatment and services, in compliance with relevant federal and state law and regulations, recognizing each person's basic personal and property rights which include dignity and individuality.

[*(3)*] **(2)** Each patient or resident and the family of such patient or resident shall, prior to or at the time of admission and during stay, receive a written statement of the services provided by the facility including those required to be offered on an "as-needed" basis, and a statement of related charges for services not covered under Medicare or Medicaid, or not covered by the facility's basic per diem rate. Upon receiving such statement, the patient and the patient's representative shall sign a written receipt which must be retained by the facility in its files.

[*(4)*] **(3)** Each patient shall receive from the attending physician or the resident physician of the facility complete and current information concerning the patient's diagnosis, treatment and prognosis in terms and language the patient can reasonably be expected to understand, unless medically inadvisable. The patient or resident shall participate in the planning of the patient's or resident's medical treatment, **including attendance at care plan meetings,** may refuse medication or treatment, be informed of the medical consequences of all medication and treatment alternatives and shall give prior informed consent to participation in any experimental research after a complete disclosure of the goals, possible effects on the patient and whether or not the patient can expect any benefits or alleviation of the patient's condition. In any instance of any type of experiment or administration of experimental medicine, there shall be written evidence of compliance with this subdivision, including the signature of the patient and a member of the patient's family or the patient's representative. A copy of the signed acknowledgments shall be forwarded to the family or representative, and a copy shall be retained by the facility.

[*(5)*] **(4)** At the bedside of each patient and resident the facility shall place and maintain in good order the name, address and telephone number of the physician responsible for the patient's care.

[*(6)*] **(5)** Each patient and resident shall receive respect and privacy in the patient's or resident's own medical care program. Case discussion, consultation, examination and treatment shall be confidential, and shall be conducted discreetly. Persons not directly involved in the patient's care shall not be permitted to be present during such discussions, consultations, examinations or treatment. Personal and medical records shall be treated confidentially, and shall not be made public without the consent of the patient or resident, except such records as are needed for a patient's transfer to another health care institution or as required by law or third-party payment contract. No personal or medical records shall be released to any person inside or outside the facility who has no demonstrable need for such records.

[*(7)*] **(6)** [*Each patient and resident has the right to be free from mental and physical abuse and has the right to be free from chemical and physical restraints (except as authorized by a physician according to clear and indicated medical requirements).*] **Every patient and resident shall be free from chemical and physical restraints, except as authorized in writing by a physician for a specified and limited period of time, or when necessary to protect the patient from injury to himself/herself or others. When authorized by someone other than a physician, such restraint shall be promptly reported to the patient's or resident's physician who may either terminate the restraint or authorize the restraint in writing for a specified and limited period of time.**

[*(8)*] **(7)** Every patient and resident shall receive from the administrator or staff of the facility a courteous, **timely,** and reasonable response to requests, **and the facility shall make prompt efforts to resolve grievances. Responses to requests and grievances shall be made in writing upon written request by the patient or resident.**

[*(9)*] **(8)** Every patient and resident shall be provided with information as to any relationship the facility has with other health care and related institutions [*insofar as the patient's care is concerned*] **and/or service providers, including, but not limited to, pharmacy and rehabilitation services, to the extent the patient is offered care and/or services from these related entities. Such information shall be provided in writing upon admission, and thereafter when additional services are offered.**

(9) Every patient and resident may contract with the providers of his/her choice, including a pharmacy, unless precluded by applicable law, as long as the providers agree to and follow the reasonable rules and regulations of the facility.

(10) Every patient and resident shall receive reasonable continuity of care *[which shall include, but not be limited to, what appointment times and physicians are available*].

(11) Every patient and resident may associate and communicate privately and without restriction with persons and groups of the patient's or resident's own choice [*on the patient's or resident's own or their initiative*] at any reasonable hour; may send and shall receive mail promptly and unopened; shall have access at any reasonable hour to a telephone where the patient may speak privately; and shall have access to writing instruments, stationery and postage.

(12) Each patient and resident has the right to manage [*the patient's or resident's own*] **his/her** financial affairs. If, by written request signed by the patient **or resident** and a member of [*the patient's*] **his/her** family or representative, the facility manages the patient's **or resident's** financial affairs, it shall have available for inspection a monthly accounting, and shall furnish the patient **or resident** and [*the patient's*] **his/her** family or representative with a quarterly statement of the patient's **or resident's** account. The patient and resident shall have unrestricted access to such account at reasonable hours.

(13) If married, every patient and resident shall enjoy privacy in visits by [*the patient's or resident's*] **his/her** spouse, and, if both are in-patients of the facility, they shall be afforded the opportunity where feasible to share a room, unless medically contraindicated.

(14) Every patient and resident has the right of privacy in [*the patient's or resident's*] **his/her** room, and personnel of the facility shall respect this right by knocking on the door before entering the patient's **or resident's** room.

(15) Every patient and resident has the right, personally or through other persons or in combination with others, **to exercise his/her rights;** to present grievances; to recommend changes in facility policies or services on behalf of [*the patient's or resident's own self*] **himself/herself** or others; to present complaints or petitions to the facility's staff or administrator, to the Division of Services for Aging and Adults With Physical Disabilities or to other persons or groups without fear of reprisal, restraint, interference, coercion or discrimination.

(16) A patient or resident shall not be required to perform services for the facility.

(17) Each patient and resident shall have the right to retain and use [*that patient's or resident's*] **his/her** personal clothing and possessions where reasonable, and shall have the right to security in the storage and use of such clothing and possessions.

(18) No patient or resident shall be transferred or discharged out of a facility except for medical reasons; the patient's **or resident's** own welfare or the welfare of the other patients; or for nonpayment of justified charges. If good cause for transferral is reasonably believed to exist, the patient or resident shall be given at least 30 days' advance notice of the proposed action, together with the reasons for the decision, and the patient **or resident** shall have the opportunity for an impartial hearing to challenge such action if [*the patient*] **he/she** so desires. In emergency situations such notice need not be given.

(19) Every patient and resident shall have the right to inspect all records pertaining to him/her, upon oral or written request within 24 hours of notice to the facility. Every patient and resident shall have the right to purchase photocopies of such records or any portion of them, at a cost not to exceed the community standard, upon written request and two working days advance notice to the facility.

(20) Every patient and resident shall be fully informed, in language he/she can understand, of his/her rights and all rules and regulations governing patient or resident conduct and his/her responsibilities during the stay at the facility.

(21) Every patient and resident shall have the right to choose a personal attending physician.

(22) Every patient and resident shall have the right to examine the results of the most recent survey of the facility conducted by federal and/or state surveyors and any plan of correction in effect with respect to the facility. Survey results shall be posted by the facility in a place readily accessible to patients and residents.

(23) Every patient and resident shall have the right to receive information from agencies acting as client advocates and be afforded the opportunity to contact those agencies.

(24) Every patient and resident shall be free from verbal, physical or mental abuse, cruel and unusual punishment, involuntary seclusion, withholding of monetary allowance, withholding of food, and deprivation of sleep.

(25) Every patient and resident shall be free to make choices regarding activities, schedules, health care, and other aspects of his/her life that are significant to the patient or resident, as long as such choices are consistent with the patient's or resident's interests, assessments, and plan of care and do not compromise the health or safety of the individual or other patients or residents within the facility.

(26) Every patient and resident has the right to participate in an ongoing program of activities designed to meet, in accordance with his/her assessments and plan of care, the patient's or resident's interests and physical, mental and psychosocial well-being.

(27) Every patient and resident shall have the right to participate in social, religious and community activities that do not interfere with the rights of other patients or residents.

(28) Every patient and resident shall receive notice before the resident's room or roommate is changed, except in emergencies. The facility shall endeavor to honor the room or roommate requests of the resident whenever possible.

(29) Every patient and resident shall be encouraged to exercise his/her rights as a citizen of the State of Delaware and the United States of America.

(30) Every patient and resident shall have the right to request information regarding minimum acceptable staffing levels as it relates to his/her care.

(31) Every patient and resident shall have the right to request the names and positions of staff members providing care to the patient or resident.

(32) Every patient and resident shall have the right to request an organizational chart outlining the facility's chain of command for purposes of making requests and asserting grievances.

(33) Where a patient or resident is adjudicated incompetent, is determined to be incompetent by his/her attending physician, or is unable to communicate, his/her rights shall devolve to his/her next of kin, guardian, or representative.

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August 5, 1998

Senator Grassley
United States Senate
Special Committee on Aging
G-31 Dirksen Senate Office Building
Washington D.C., 20510

RE: Addendum to the Senate Recorded Minutes of the Testimony of Leslie Oliva for Maria Elena Espinoza on July 27, 1998

Senator Grassley and Members of the Committee:

Extended Care Hospital Of Riverside ("Extended Care") thanks The United States Senate Special Committee on Aging for allowing it the opportunity to respond to, clarify and correct portions of the oral and written testimony of Leslie Oliva.

With all due respect, Extended Care recognizes the emotional conditions which brought Ms. Oliva before the Committee. However, Extended Care believes that Ms. Oliva's emotions seriously interfered with her ability to provide accurate and correct testimony.

Extended Care's information is verifiable for the most part by written documentation recorded at the times the various events transpired. An accurate chronology of what occurred and when it occurred is important.

Ms. Oliva's testimony indicates her mother was treated at three separate skilled nursing facilities. Ms. Oliva's testimony goes back and forth in time. It is not clear from the record at which facility and when the alleged events occurred. This type of testimony is unfair in that Extended Care should not be held attributable to or have its name and reputation disparaged due to isolated actions of others or innuendo.

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Ms. Oliva testified that her mother suffered from a condition known as Huntington Corea Disease for approximately 13 years until she passed away at the age of 56 years.

Huntington Corea is a genetic disorder in which paired nerve cell clusters in the brain degenerate resulting in chorea (rapid, jerky, involuntary movements) and dementia. The chorea usually affects the face, arms and trunk resulting in random body movements and clumsiness. Personality and behavioral changes include irritability and memory loss.

These symptoms can cause a patient such as Mrs. Espinoza to be difficult to care for. As Ms. Oliva testified, when she herself was the primary care provider for her mother the amount of care and attention her mother required was so great that it created physical and emotional tolls on Ms. Oliva and her family. The care and stress to Ms. Oliva were so much that Ms. Oliva was compelled to admit her mother to a nursing home. Ms. Oliva admitted that the stress and physical burden caused her to feel like a victim of the illness. Understandably there is sometimes an association of guilt experienced by a family who for various reasons must place a parent in a skilled nursing facility. Quite often the placement is against the express wishes of such parent. Based on the guilt, the family loses objectivity, is quick to deter blame and is unduly critical of the care provided by the skilled nursing facility.

When a resident such as Ms. Espinoza is admitted to a skilled nursing facility from a home environment there is sometimes depression and/or anger from the resident associated with the transfer. Many residents, even those suffering from various stages of dementia, know they are in a nursing home and do not like being there simply because it is not home. As such, the residents are sometimes not as cooperative with the staff as they are when their own family member is the person providing the care.

It should be recognized that the majority of family members of residents at Extended Care are pleased with the care provided to the residents. Excellent examples (relative to the lack of objectivity on Ms. Oliva's part) are the letters from Zenobia Woods and Oscar L. Gibbs to the Press Enterprise Newspaper of Riverside, California. True and correct copies of the letters are attached hereto as Exhibits "A" and "B" respectively.

Ms. Woods and Mr. Gibbs are neutral and objective observers. Their perspectives, especially as they address the specific care in question should be highly regarded. Ms. Woods and Mr. Gibbs both represent that their direct observations of the care provided to Ms. Espinoza was that it was quite good. A letter from Vicki Contri to the Press Enterprises (Exhibit "C") expresses the view of other individuals who have family members placed at Extended Care.

Ms. Espinoza's illness and the symptoms associated with it caused her to be susceptible to bruising. Rapid, involuntary, jerky movements and the agitation associated with placement, a medical condition or dementia sometimes cause residents such as Mrs.

Espinoza to strike out and bruise themselves. The history provided by Ms Oliva indicated that the heavy bruising her mother suffered went back to April, 1995 when Ms. Oliva was first placed at Orangetree Convalescent Hospital.

Relevant factors documented in Ms Espinoza's medical chart which contradict the allegations and implications of Ms. Oliva are as follows:

Dates of Service. According to Ms. Oliva's written testimony, her mother was admitted to Extended Care on June 17, 1997. Documentation shows Mrs. Espinoza had two admissions June 6, 1996 (discharged June 12, 1996) and June 17, 1996 (discharged January 5, 1998). Though certain allegations mildly resemble factual data, the dates provided in Ms. Oliva's testimony do not concur with dates documented in the medical record.

Weight Loss. Ms. Espinoza's admitting weight on her first admission was 102 pounds and on her second admission was 96 pounds. Her weight upon discharge January 5, 1998 was 123.2 pounds. This translates to a 27.2 pound weight gain or a 28.34% increase.

Dehydration. Continuous documentation in both charts shows that Mrs. Espinoza was well hydrated. Water or other beverages were offered and accepted numerous times daily. There were no clinical signs of dehydration.

Pressure Sores. Upon Mrs. Espinoza's admission on June 6, 1996, she had a Stage II pressure sore. It was completely healed before discharge on June 12, 1996. During the 1 ½ years Mrs. Espinoza was at Extended Care, she never developed any pressure sores.

Personal Items. None of the items mentioned were listed on either inventory sheet used upon admission. During the initial admission, the resident was not supplied with any personal items. During her second admission, the personal item inventory was rather slim. Social Services Designee documentation shows the need for more personal items. The facility supplied clothing and other needed belongings. Side rail pads, costing several hundred dollars, were supplied by the facility. All safety pads, positioning devices, splints, bibs and other linen items were also supplied by the facility.

Dentist Visits. Mrs. Espinoza was seen by Dr. Pollard, D.D.S. on October 6, 1997 and November 3, 1997.

5150 Based upon Ms. Oliva's testimony, she does not understand the meaning of this term. California Welfare and Institutions Code §5150 provides as follows:

> "When any person, as a result of a mental disorder, is a danger to others, or to himself or herself, or gravely disabled, a peace officer, member of the attending staff, as defined by regulations, of an evaluation facility designated by

the county, designated members of a mobile crisis team provided by Section 5651.7, or other professional person designated by the county may, upon probable cause, take or cause to be taken, the person into custody and place him or her in a facility designated by the county and approved by the State Department of Mental Health as a facility for 72-hour treatment and evaluation .."

Here, Extended Care had reasonable grounds to believe that Mrs. Espinoza was a danger to herself and others as a result of her mental disorder. Extended Care acted consistent with its duty of care towards Mrs. Espinoza and others by seeking to have her placed in a separate facility for 72-hour treatment and evaluation. Medications can not and are not give without a doctor's order. Extended Care does not even own a straight jacket.

Conversation With Administrator. Extended Care's Administrator, Glen Goldsmith, was misquoted on all questions asked. Several other questions and answers presented and quoted by Ms. Oliva were never asked.

Threats to Discharge Immediately. There was no documentation in the chart to support these allegations. Numerous calls to Ms. Oliva were documented from October 1997 until Mrs. Espinoza was discharged on January 5, 1998.

Christmas Visit. No visitors were noted to have come into the facility on Christmas Eve or Christmas Day, 1997. No documentation (signed out on pass) was noted in the chart for Christmas Eve, 1997. Mrs. Espinoza did go home on pass Christmas, 1996. The facility practice and procedure dictates that staff would document family visiting in the building with residents until 3:45 a.m.

Agitations/Striking Out. Ms. Oliva refuted facility claims of her mother yelling, screaming and getting out of bed. She stated "During my mother's stay at home with us she never did such a thing." She also stated "Anyone could see that these injuries could not have come from a fall or have been caused by my mom herself." Beginning at the end of November, 1997, until discharge, Mrs Espinoza exhibited the following behaviors:

Crying/sobbing for her mother
Hit several C.N.A.'s
Yelling/screaming at all hours
Striking out at caregivers and others
Standing on bed, ready to jump
Stood up from the wheelchair with the wheelchair seat belt on
Slammed face/head on floor
Wrapped call cord twice around neck
Stuck extremities through bed rails

Falls. From October 5, 1997 to January 5, 1998 Mrs. Espinoza experienced at least 12 episodes of falls (1-4 times per episode) from her bed or chair. All falls are fully documented. The bed rails were fully padded and in the up position when Mrs. Espinoza fell from bed.

Extended Care can not verify what occurred or did not occur at the nursing homes Mrs. Espinoza resided at before and after her admissions at Extended Care. Extended Care can verify that while Mrs. Espinoza was at Extended Care more than reasonable efforts were made to provide the proper level of care. Mrs. Espinoza was at Extended Care almost a year and a half. The injuries which she suffered due to her physical, mental and emotional conditions were documented and investigated. When Mrs. Espinoza's condition became a threat to herself, the staff, other residents and guests, Extended Care sought a psychiatric consultation and reported the condition to the family. Ms. Oliva may have financial motive for her incorrect testimony in that she has retained an attorney who provided Extended Care with a notice of intent to sue. Ms. Oliva's misconceptions of the care provided at Extended Care for her mother may be totally innocent and reflective of guilt for having to place her relatively young mother (56 years of age) in a skilled nursing facility.

Extended Care expresses sympathy to Ms. Oliva for the loss of her mother. Extended Care understands how Ms. Oliva's perception of the care provided may be skewed. However, a public record of allegations which can not be substantiated requires Extended Care to make this addendum. Any fair consideration should hear all sides. When investigated thoroughly, sensationalized reports are often found to be exaggerated and inaccurate. Hopefully, the explanations of Extended Care and the information in the letters from Ms. Woods, Mr. Gibbs and Ms. Contri will give the Committee a better opportunity to make objective and carefully considered determinations.

Respectfully,

Glen Goldsmith

Glen Goldsmith, Administrator
Extended Care Hospital of Riverside

TO: The Press Enterprise
ATTN: Oncil R. Soto
RE: 'Nursing Homes on Senate Carpet"
DATE: July 29, 1998
FROM: Zenobia Woods

My grandmother, Zenobia Howell, shared a room with Marie Elena Espinoza at Extended Care on Magnolia in Riverside. I can testify the attention given her during the times I visited my grandmother was extraordinary. I particularly pay attention to how the staff treats residents when their families are not around. Because of the way Marie was treated, I felt even more comfortable leaving my grandmother with such wonderful and caring people.

I cannot express the guilt I feel for being too busy to write to Extended Care to express my appreciation for taking care of my grandmother. One can only look at her picture in the Press Enterprise, dated March 26, 1998, taken on her 100th birthday to see how well she is taken care of. Caring for the very young, the very old and the very sick is a very difficult job. In some cases what seems to be abuse isn't abuse at all, but rather the unavoidable result of the person's condition.

When I'm not working, I visit often three or four times a week. I have seen first-hand the love and care that is shown to each resident by the staff at Extended Care. I have two sisters-in-law who are registered nurses, one working at a nursing home, the other working directly with various nursing facilities. Both have visited my grandmother and had nothing but praise.

I look forward to reading this letter in the Press Enterprise. That's the least we can do to let these hard-working people know that there are many who are standing by their side. We must uplift, not discourage. We are able to do our jobs because they do theirs.

God bless these heavenly sent angels at EXTENDED CARE.

Sincerely yours,

Zenobia W. Woods

EXHIBIT A

July 29, 1998

The Free-Enterprise
P.O. Box 792
Jonesville, Ga.

Dear Editor:

My wife, Virginia Eller, entered Eatonton Hospital on Feb 9, 1997. For the next 2 months she shared a room with Maria Espinoza and was cared for by the same nurses and technicians. The care was adequate and usually good. When I called I got [illegible] and frequently [illegible].

Although Virginia's surgeon has the final say on all matters of Mrs. Eller's medical treatment, the nurses and technicians are the ones who administer, analyze, and consider the care of Patients' [illegible] and other needs.

Sincerely,
[illegible]

EXHIBIT B

July 29, 1998

The Press Enterprise
P.O. Box 792
Riverside, CA

Dear Editor:

My wife, Virginia Gibbs, entered Extended Care Hospital on Feb. 9, 1997. For the next ten months she shared a room with Marie Espinoza and was cared for by the same nurse and assistants. The care was adequate and usually quite good. When I can, I go to see my wife everyday and frequently twice a day.

Although I didn't recognize her, that was an excellent picture of Mrs. Oliva. I wish you had taken an equal amount of time and space to investigate, analyze and compare the care of Extended Care and other nursing homes.

Oscar L. Gibbs

TRANSCRIPTION OF EXHIBIT "B"
(Handwritten letter of Oscar L. Gibbs)

July 31, 1998

Readers Open Forum
Press-Enterprise
P. O. Box 792
Riverside, California 92502

Gentlemen:

This letter is in regard to the article in the July 28th Press-Enterprise specifically regarding Extended Care Hospital of Riverside. My aunt resided in Extended Care for approximately three years during the last stages of Alzheimer's. The disease had come to the point where my aunt was no longer able to care for herself and required 24 hour care and supervision.

After extensive research into a majority of the convalescent and custodial care facilities in the area, I found that Extended Care Hospital of Riverside had the least and most minor infractions than any of the others I had researched. My husband and I made a surprise visit to tour the facility and were shown everything and met everyone. We were impressed with the facility, its cleanliness, and with the genuine warmth and caring in all we met.

During my aunt's stay at Extended Care and as the illness progressed, she was always treated with respect and love. My husband and I visited my aunt and other patients there, as well as the staff, at least twice a week. If any concerns arose, they were taken care of almost immediately. She gained weight during her stay and flourished in the loving atmosphere we experienced at Extended Care Hospital of Riverside. Thank you for this opportunity to express my thanks to all those who showed the love of God to my aunt and who helped to make passing from this life much easier for her and for us.

Very truly yours,

Vicki Cantu

Vicki Cantu
23820 Ironwood Avenue
Moreno Valley, CA 92557
(909) 924-4364

EXHIBIT C

SPECIAL COMMITTEE ON AGING

UNITED STATES SENATE

Hearing on Quality of Care in
California Nursing Homes
July 27-28, 1998

Statement for the Record

By Orangetree Convalescent Hospital, Inc.

August 5, 1998

I. Orangetree Convalescent Hospital, Inc.

Orangetree Convalescent Hospital, Inc., is a California corporation all of whose shares are owned by Thomas E. and Elizabeth R. Plott. Its exclusive business activity is the operation of Orangetree Convalescent Hospital ("Orangetree"). Convalescent hospitals are long-term health care facilities commonly referred to as nursing homes.

Located in Riverside, California, Orangetree has been owned by the Plotts since August of 1984. It is a 146 bed skilled nursing facility that continuously has been certified for Medicare and Medi-Cal (California's Medicaid program) since it was purchased by Mr. and Mrs. Plott. Its current average daily census is 122. In the spring of this year, the census dipped to its present level when the county hospital that was next door, a primary referral source, relocated to a site 45 minutes away. For the three years prior to this, the average daily census has ranged annually between 131 and 140.

As of July 28, 1998, Orangetree employed 119 individuals on a full-time basis. This includes 60 Certified Nurses Aides ("C.N.A.s"), 15 licensed vocational nurses, 8 registered nurses, and 1 medical social worker. Additionally, the provision of care is supervised by Mrs. Plott, a Registered Nurse ("R.N.") and a Licensed Clinical Social Worker with over 35 years of skilled nursing facility management experience, who is the Administrator. She is joined in this supervision by another R.N. who has been

the Director of Nurses at Orangetree for almost 5 years, as well as an Assistant Administrator who has over fifteen years of long-term care experience, including a number of years as a certified nursing assistant.

As with all California nursing homes, Orangetree employs no physicians; each patient retains the services of a physician independently. However, a licensed physician is contracted by Orangetree to participate in the supervision of the nursing care provided. His functions include the following: being responsible for standards, coordination, surveillance, and planning for improvement of medical care; establishment of patient care policies; and oversight of the rehabilitation therapy program. These functions are accomplished through participation in the monthly and quarterly activities of Orangetree's Quality Assurance Committee as well as by acting as a liaison with other physicians who are caring for patients placed at Orangetree.

Orangetree's Quality Assurance Committee includes the Medical Director, another physician attending Orangetree patients, the Administrator, the Assistant Administrator, the Director of Nurses, the Dietitian, and a member of the Board of Directors. All actions of the Committee are documented in meeting minutes. The purpose of the Committee is to evaluate, monitor, and review issues affecting patient care.

On a monthly basis, the Committee discusses, monitors, and evaluates any patients who have decubitus ulcers, statis ulcers, fractures, problems concerning weight loss or gain, orders for

tube feeding, orders for restraints, behavior problems, orders for psychoactive or behavior-altering medications, or other significant medical issues. Additionally, the Committee reviews all new admissions to ensure that all patients are properly placed, and evaluates all discharges. The Committee also reviews all incident reports, monitors all falls, evaluates any patient who is isolated due to infection, and monitors other areas of the facility operations from the previous month that have an impact on the provision patient care, including staffing, maintenance, theft and loss policies, and infection control also are discussed. These monthly meetings are not required by state or federal regulations. However, Orangetree has found them essential to the provision of quality care.

On a quarterly basis, the Quality Assurance Committee reviews ancillary services, including clinical laboratory, pharmacy, and x-ray. These meetings include the individuals who are present during the monthly meetings as well as the pharmacy consultant, X-ray consultant, and laboratory consultant. These individuals review the results of the previous month's drug regimen reviews performed by the consulting pharmacist monthly, evaluated the status and prevention of infections, and other relevant aspects of patient care. Further, the Director of Nurses holds a weekly meeting with rehabilitation and respiratory therapists who are attending Orangetree patients. Combined, Orangetree's quality assurance activities ensure that its patients are attaining or maintaining their highest practicable

physical and psychosocial well-being as directed by federal regulations.

Also vital to quality care are community physicians who direct the nursing care provided to facility patients. Orangetree maintains a list of physicians who are willing to provide services to nursing home patients. This list and other assistance are offered to the patients who do not have a regular physician or whose regular physician does not see patients in nursing homes.

For two reasons beyond Orangetree's control, this list is limited: (1) low physician compensation--based on three levels of service acuity, physicians are paid between $11 and $31 by Medi-Cal, and between $26 and $58 by Medicare (this varies by county as well as by acuity) to provide all services to a California nursing home patient in a month; and (2) physician call requirements -- a nursing home physician in California is expected by the state nursing home regulators (although not required by statute or regulation) to make immediate, direct verbal contact with a nurse over every aspect of a patient's medical care, including not only emergencies and significant care issues, but also simple, non-urgent matters such as superficial scratches, falls resulting in no injury, and clinical laboratory tests within normal ranges. For example, it is not uncommon for a physician to be called at 3:00 a.m. to be informed that a 1 cm. skin tear (scratch) was found on a patient's knuckle when he was

assisted to the bathroom minutes before or that the patient fell while walking to the bathroom and sustained no injury.

Orangetree cares for a wide variety of individuals with a broad spectrum of medical ailments including Cerebrovascular Accidents (strokes), Hypertension, Seizure Disorders, Congestive Heart Failure, Renal Failure, Huntington's Chorea, Diabetes Mellitus, Atherosclerotic Heart Disease, Peripheral Vascular Disease, Paraplegia, Quadraplegia, and Tramatic Brain Injuries (the later three often are caused by vehicular accidents or gunshot wounds), as well as chronic disabilities caused by drug and alcohol addiction. Based on reports that are filed annually with the State of California detailing the demographic make-up of a facility's census on the last day of the calendar year, on December 31, 1997, 7.3% of Orangetree's patients were under 45 years of age, 30.6% were between 45 and 64, 43.1% were between 65 and 84, and 19% were over 84.

In June of 1998, 91.8% of the care provided to Orangetree's patients was paid for by Medi-Cal, 0.0% by Medicare, 9.9% by private funds, and 3.2% by other sources. The current per diem rate paid by Medi-Cal, Orangetree's patients' primary source of payment, to nursing homes in California of the same size and geographic location as Orangetree is $84.99. When the budget for California's current fiscal year is passed, it is anticipated this rate will rise to just over $91.00. (Although this is an increase, it is projected by industry experts to be insufficient

to meet the increased costs arising from the new mandate for MDS transmission.)

This rate includes: a semi-private room; all meals (including special diets, snacks, and nourishments); nursing services (including assessment, observation, coordination of other services, and medication administration); related care services (including medical social services, and activities); commonly used equipment; personal and medical supplies; personal grooming services (including routine beauty and barber services); and personal laundry services.

Orangetree's owners and dedicated staff pride themselves on providing quality services and meeting the specific medical and psycho-social needs of each patient. Orangetree has never committed gross, systematic neglect and abuse such as that attributed to it in the written and verbal testimony provided to the Senate Special Committee on Aging (the "Committee") by Ms. Leslie Oliva. Unfortunately, at the July 27 Hearing, Ms. Oliva portrayed a very distorted picture of the care Orangetree provided to her mother, Ms. Espinoza, for just over 8 months in 1995. Because this testimony was so inaccurate and inflammatory, Orangetree is compelled to submit this Statement to correct the Committee Record.

II. Huntington's Chorea Disease.

As Ms. Oliva testified, her mother was admitted as a patient at Orangetree in April of 1995 with Huntington's Chorea Disease

("Huntington's"). According to Ms. Oliva's testimony, Ms. Espinoza had exhibited signs and symptoms of Huntington's for 10 years prior to her admission at Orangetree.

Sadly, Huntington's is one of the worst afflictions any human being can experience. According to standard medical knowledge, this disease is "inexorably progressive; no treatment is known." The Merck Manual, 16th Edition, p. 1493. As such, it is not preventable, treatable, or curable. It is a genetically transmitted disease whose onset generally occurs between the ages of 35 and 50, and has a typical duration of 10 to 15 years. It always ends in death.

Huntington's is "characterized by choreiform movements [brief, purposeless, involuntary movements of the distal extremities and face] and progressive intellectual deterioration." The Merck Manual, 16th Edition, p. 1493. The signs and symptoms often include: "flicking movements of the extremities, a lilting gait, a motor impersistence (inability to sustain a motor act such as tongue protrusion)," and "facial grimacing, ataxias [a reeling, wide-based gait], and dystonia [sustained abnormal postures and disruptions of ongoing movement resulting from alterations in muscle tone]." Id. at 1494.

Additionally, persons with Huntington's often suffer from "psychiatric disturbances, ranging from personality changes of apathy and irritability to full-blown manic-depressive or schizophreniform illness . . . ." Id. at 1493-94. As the disease progresses, persons with Huntington's can cause serious

harm to themselves from their erratic, uncontrollable motor activity and as a result of depression, both arising from the inevitable neurogenic deterioration. For the sake of comparison, it can be said that Huntington's is to muscular disorders what Tourette Syndrome is to verbal disorders.

As Huntington's is an inherited disease -- any child of a parent with Huntington's has a 50 percent chance of inheriting the disease -- Ms. Oliva herself is at significant risk for contracting Huntington's, as are her six siblings and any biological child she may have.

III. The Care and Treatment Provided to Ms. Espinoza by Orangetree.

Orangetree maintains a full set of medical records for all patients in accordance with generally accepted medical documentation parameters. Orangetree's medical records regarding Ms. Espinoza are complete and were developed daily throughout her stay. The following statements are based on those records.

Ms. Espinoza was admitted to Orangetree on April 14, 1995. The day before her admission, she was admitted to the Emergency Department of an acute hospital in a neighboring community. According to the acute hospital records provided to Orangetree at the time of Ms. Espinoza's admission, she was brought to the Emergency Department, at approximately 1:50 p.m. on April 13, because she was "thrashing about" and was "found" with a "knife." A family member with her at the Emergency Department "state[d] pt

became agitated [at] home & approached [daughter] w/ knife" and was quoted as saying "this happens every time her med[ication]s get off."

The assessments of the acute hospital Emergency Department nurse who evaluated Ms. Espinoza upon her arrival were:

1) "mental status . . . Restless . . . Agitated;"

2) abnormal physical and mental conditions presented:

   a) "Neuro . . . thrashing in bed [history] of Huntington's Chorea;"

   b) "Head . . . dry cracked lips;"

   c) "Skin . . . healing wounds L foot dry;"

   d) "Psy[chological status] . . . difficulty expressing [due to] Huntington's Chorea."

The care provided by the acute hospital Emergency Department included:

1) "soft restraints on all 4 extrem[ities]; side rails padded to protect pt . . .;" and

2) IV administrations of Haldol and Benadryl (both medications used to treat the agitation and thrashing associated with Huntington's) as well as Claforan (an antimicrobial medication).

At 6:30 p.m. that same evening, Ms. Espinoza was discharged from the Emergency Department and admitted as an inpatient to that hospital. Upon this transfer, her diagnoses were acute dehydration and Huntington's Chorea.

The next day, she was discharged from the acute hospital and admitted to Orangetree a short time later. Again, on transfer, her primary diagnoses were Huntington's and dehydration. She also was noted as having an "old abrasion to [her] left heel."

As Ms. Espinoza did not have a regular attending physician, one was chosen for her from Orangetree's physician list. This physician gave the initial admitting orders and continued to care for Ms. Espinoza throughout her entire stay at Orangetree. On April 15, 1995, the day after her admission, he personally examined her and completed a History and Physical Examination. In it, he confirmed the diagnoses identified at the acute hospital. Her physician also documented that Ms. Espinoza's rehabilitation potential was poor, as would be expected for anyone suffering from Huntington's.

The best care that can be provided for someone suffering from this disease is all directed toward the management of the symptoms as the patient's condition slowly and inevitably deteriorates. From the day of Ms. Espinoza's admission, Orangetree provided her good, appropriate nursing services in a competent, caring manner. Her care included initial and continuing assessments that resulted in a Care Plan which addressed her physical and mental deteriorations. Her long-term

care goals were identified as "provide safe environment [to] prevent injuries-improve hydration." The specific care problems for which care approaches were developed following Ms. Espinoza's admission to Orangetree included:

1) impaired communication due to neurological impairment;

2) impaired physical coordination and mobility resulting from neurological impairment (evidenced by thrashing, constant jerking movements, poor body alignment when in a wheelchair);

3) incontinence of bowel and bladder;

4) low body weight on admission (93.8 lbs.);

5) history of dehydration; and

6) self-abuse such as striking herself.

As additional care issues arose, her Care Plan was updated to include approaches for the following problems:

1) restlessness related to Huntington's Chorea (added September 23, 1995 and upgraded to extreme December 21, 1995);

2) Dysphagia (swallowing difficulties) (added October 19, 1995 and again December 21, 1995); and

3) Anorexia (self-imposed eating difficulties) related to depression (added November 11, 1995).

During her stay at Orangetree, Ms. Espinoza was seen by her physician 9 times as well as seen by a consulting psychiatrist 11 times. The orders given for Ms. Espinoza's care at Orangetree by her physician upon admission included:

1) continuation of the Haldol and Benedryl prescribed by the acute hospital physicians for her thrashing;

2) regular diet;

3) high protein nourishments three times a day in-between meals.

4) bedrails up when in bed;

5) soft waist restraint while in bed or wheelchair; and

6) heel abrasion treatments.

Following this set of initial orders, Ms. Espinoza's physician and attending psychiatrist adjusted and changed the orders for her care many times throughout her stay after consultations with Orangetree's nurses, other professionals, and with Ms. Espinoza. These adjustments and changes included:

1) On April 15, 1995, adding padding to her bedrails in an effort to protect her from self-inflicted injuries resulting from her thrashing;

2) On April 15, 1995, adding a geri-chair (a lounge-style wheelchair) for safety;

3) On April 27, 1995, and continuing through December 21, 1995, multiple adjustments to the Haldol and Benadryl orders attempting to control her thrashing and self-abusive behaviors, such as striking herself and refusing care, while not over-medicating her;

4) On April 28, 1995 (two weeks after admission), discontinuation of the heel abrasion treatments when it was healed;

5) On June 6, 1995, adding bowel and bladder retraining for 4 weeks in an effort to see if any normal bladder function could be relearned (this was unsuccessful);

6) On September 23, 1995, adjusting the Benadryl order to address new drooling behavior;

7) On October 6, 1995, replacing the geri-chair use with a wheelchair and a pelvic restraint;

8) On October 18, 1995, directing an evaluation by a qualified therapist due to her decreased eating;

9) On October 19, 1995, changing her diet as a result in the speech evaluation from regular to puree;

10) On October 19, 1995, adding Cogentin to address the development of Extrapyranidal Side Effects (movement disorders arising as a side effect of drugs such as Haldol);

11) On October 19, 1995, adding six sessions of speech therapy to address the dysphagia identified during the speech therapy evaluation;

12) On October 25, 1995, adding thickened liquids to address the swallowing difficulties;

13) On November 11, 1995, adding Pamelor for the new diagnosis of Anorexia secondary to the depression arising from Huntington's;

14) On November 19, 1995, discontinuing all restraints because Ms. Espinoza was attempting to avoid them, thereby causing a greater risk of harm than that arising from the absence of the restraints;

15) On December 21, 1995, instituting a 24 hour "drug holiday" in an effort to control increased restlessness and a recurrence of swallowing difficulties;

16) On December 21, 1995, reinstituting bedrail padding following pronounced thrashing; and

17) On December 23, 1995, instituting treatment for a skin tear on her coccyx that she self-inflicted along with bruising on her left shoulder and injuries to her right eye area during her thrashing the night before.

Ms. Espinoza's initial and quarterly Minimum Data Sets (a federally approved assessment form) and Care Plans were completed and updated timely under the supervision of the Director of Nurses. Ms. Espinoza attended the care planning meetings, although Ms. Oliva, who was invited in writing, did not.

Ms. Espinoza's status was documented daily by the C.N.A.s caring for her. This documentation included assessments of her grooming and hygiene, eating habits, as well as other personal care issues. It reflects that she was clean and was provided appropriate assistance with activities of daily living. Additionally, her care was evaluated weekly, or more often if changes in her conditions warranted, by Orangetree's licensed nurses. Also, her medications and treatments were administered daily by the licensed nurses. Ms. Espinoza participated in the activities program to the extent she wished. She was seen by a podiatrist and a dentist while at Orangetree. She also was assessed and monitored by both the Dietitian and the Social Worker.

Ms. Espinoza's acute dehydration was addressed through the I.V. therapy at the acute hospital prior to her arrival at Orangetree. However, throughout her stay at Orangetree, the

nursing staff continued to ensure it did not recur. The C.N.A.s caring for her encouraged fluids, both during meals and in between. Twice daily, individual pitchers are placed on each patient's bedside. Moreover, during medication administrations, which Ms. Espinoza had two to three times daily, the licensed nurses provide juice and/or water. As such, while at Orangetree, Ms. Espinoza did not have a recurrence of dehydration.

Ms. Espinoza was 5 feet tall. When she was admitted to Orangetree, she weighed 93.8 lbs. When she left Orangetree in December, she weighed 101.4 lbs. At her highest weight during her stay at Orangetree, she was 30.6 lbs. over her admission weight.

Upon admission, the nursing staff assessed Ms. Espinoza as underweight. After consulting with her physician, orders for a regular diet and high protein nourishments three times a day between meals were obtained. These nourishments were administered by both the licensed nurses and the CNAs. The nurses also designated her an "assisted feeder" upon admission and she was assisted by the C.N.A.s during meal time.

Despite this, when Ms. Espinoza was weighed a week and a half later, on April 27, 1995, her weight had dropped by 2.4 lbs. to 91.4. A small loss like this is not unusual for newly admitted patients. Ms. Espinoza was evaluated by the Registered Dietitian contracted by Orangetree on April 30, 1995. The Dietitian felt the diet protocol set-up by Orangetree's nurses with her physician was appropriate.

When Ms. Espinoza was again weighed on May 21, 1995, she was 97.8, a gain of 6.4 lbs. Her physician was notified, but as this was a desired gain, he did not make any new orders. On June 21, 1995, when she was weighed, she had another gain, this time 7.6 lbs., up to 105.4 lbs. Again, her doctor was notified of this beneficial increase with no new orders noted. On July 11, 1998, Ms. Espinoza was seen by the Dietitian who confirmed that the weight gain was good.

When Ms. Espinoza was weighed on July 21, 1998, she was 111.8, a new gain of 6.4 lbs. As before, her physician was contacted and he made no new orders. In August she gained another 1.8 lbs. When she was weighed on September 21, 1998, she had gained another 10.8 lbs and reached her highest weight at Orangetree, 124.4 lbs. Again, her doctor was notified and he gave no new orders. Two days after that, her Benadryl order was adjusted to address her new drooling behavior.

In October, Ms. Espinoza was weighed on the 21st. She was 123.4 lbs., a loss of 1 lb. In November, she weighed 122, a loss of 1.4 lbs. Even though her weight was relatively stable during this period, Orangetree's nurses were concerned that she was showing signs of changed eating patterns and contacted her physician. In October, her physician and Orangetree's nurses arranged for a swallowing evaluation that led to swallowing therapy by a licensed therapist and a change in her diet to puree followed by the addition of thickened liquids to assist her in swallowing. She was assessed again by the Dietitian who

confirmed the changes in her condition and eating patterns. On November 11, 1995, her psychiatrist diagnosed her as having Anorexia, apparently a result of the depression arising from Huntington's. Additionally, swallowing difficulties were noted to re-emerge on December 21, 1998.

Despite these coordinated attempts to manage her functional decline, when Ms. Espinoza was weighed on December 23, 1995, she weighed 101.4, a loss of 20.6 lbs. Although this was still approximately 10% over her admission weight of 93.8 lbs., it was not desirable. However, Orangetree's staff never had a chance to address this weight loss as December 23, 1995, was Ms. Espinoza's last day in the facility.

While at Orangetree, Ms. Espinoza had two skin integrity issues but neither of them was a bed sore (pressure ulcer). There were no photographs taken of either one while Ms. Espinoza was at Orangetree. The first issue was the left heel abrasion with which she was admitted from the acute hospital. This did not involve multiple or deep layers of skin and was healed within two weeks as a result of the treatments administered by Orangetree's nursing staff. The second issue was the skin tear on her coccyx that developed from her extreme thrashing on the night of December 22, 1995, following the 24 hour "drug holiday" ordered by her psychiatrist the day before. She was discharged to her daughter's care the next afternoon for the Christmas holiday with treatment supplies and instructions.

At no time during Ms. Espinoza's stay did she suffer any broken bones, much less a broken pelvis. From the time she was admitted until she left with her daughter on December 23, 1995, she was ambulating with assistance. She did have two falls while ambulating independently, one on November 7, 1995, and another on November 28, 1995, but she suffered no injury. Both of them occurred after Ms. Espinoza's restraints used to guard her against her lack of safety judgment and her failure to ask for assistance in ambulating as well as her deteriorated motor functions had to be discontinued due to her repeated attempts to release or circumvent them.

The incident which caused the nursing staff to obtain her physician's approval for discontinuing the restraints occurred on November 19, 1998. Ms. Espinoza was found attempting to walk with her wheelchair held on her back by the pelvic restraint intended to assist her with body alignment while seated in the wheelchair. In the professional opinion of Orangetree's nurses, this behavior posed a more significant risk of injury to her than allowing her to ambulate independently within her limitations. These falls were both reported to her physician and to her daughter when they occurred.

The only times Ms. Espinoza left Orangetree during her stay were on two holiday passes with her daughter, one for Thanksgiving and the other for Christmas. Ms. Oliva picked her mother up on November 23, 1995, stating that she would be taking her mother home for four days. However, Ms. Oliva returned her

mother to Orangetree only two days later. For Christmas, Ms. Oliva picked her mother up on December 23, 1995 at 3:15 p.m. This was the afternoon after the difficult night suffered by Ms. Espinoza.

During the prior night, Ms. Espinoza had the severe thrashing that resulted both in a skin tear on her coccyx and injuries to her face/eye. When these were noted by Orangetree's nursing staff, her physician was contacted. The nurse also attempted to reach Ms. Oliva by telephone. However, she could not because Ms. Oliva's telephone number was changed and Ms. Oliva had not provided Orangetree with the new one. Coincidentally, Ms. Oliva called at 11:00 a.m. that day to tell the facility she was taking her mother home for three days. The nursing staff then was able to inform her about the incident.

When Ms. Oliva arrived at the facility four hours later to pick up Ms. Espinoza, Ms. Oliva expressed concern about the injury to Ms. Espinoza's eye. A licensed nurse again called Ms. Espinoza's physician. After consulting with the nurse, he confirmed that he felt there was no treatment necessary or appropriate. He did indicate that if Ms. Oliva felt strongly about it, she should take her mother next door to the county hospital's emergency room. Thereafter, she took her mother home.

Ms. Oliva never returned Ms. Espinoza to Orangetree after this holiday outing. At 9:45 a.m. on December 28, 1995, Orangetree's Social Worker called Ms. Oliva to inquiry about her intentions. At that point, Ms. Oliva told the Social Worker that

she had not decided whether she was going to return her mother and indicated she was concerned about her mother's injuries. The Social Worker reviewed with Ms. Oliva the thrashing incident on the night of December 22, 1995, as well as the overall increase in her mother's agitation. During this conversation, Ms. Oliva indicated several times that she planned to contact an attorney, but ended by instructing the Social Worker to continue to hold Ms. Espinoza's bed for her.

On January 4, 1996, still having no additional communication from Ms. Oliva, the Social Worker called and left a message for Ms. Oliva asking about her intentions. On January 5, 1995, thirteen days after she took her mother home, Ms. Oliva called the Social Worker and told her she was not bringing her mother back. Ms. Oliva also asked, for the first time, for her mother's doctor's name and phone number as well as medication for her mother. From that time on, Orangetree had no contact with Ms. Oliva, her mother, or anyone representing them. Moreover, there is no record of any Ombudsman or State Health Department investigation about the care Ms. Espinoza received at Orangetree. Taken as a whole, Ms. Espinoza's medical record reflects that she was not dehydrated or malnourished nor neglected, beaten, or abused while at Orangetree. Her care needs were identified and addressed by Orangetree's professional nursing staff in coordination with a plenitude of other medical professionals.

IV. Inconsistencies of Ms. Oliva's Statement and Orangetree's Statement.

It is apparent that the Statement of Ms. Oliva is contrary to Orangetree's Statement to the Committee in a number of material respects. Orangetree has documentary evidence to support its Statement. Nevertheless, the purpose of this Statement is not to challenge the veracity of Ms. Oliva. Ms. Oliva's mother has suffered a slow and painful death, her body and her mind gradually destroyed by a terrible, incurable disease which Ms. Oliva is herself at risk of contracting. Huntington's often causes patients to inflict harm upon themselves and others. It is the professional opinion of Orangetree that any physical injuries Ms. Espinoza may have had when she left Orangetree were self-inflicted, either intentionally or unintentionally, as she was tortured by this pernicious disease and occurred in spite of the thoughtful, coordinated care Orangetree provided her.

Orangetree is profoundly sorry about the painful terminal illness suffered by Ms. Espinoza, and for the anguish that her daughter, Ms. Oliva, has experienced watching her mother suffer. However, Orangetree did not contribute to that suffering; in a competent and professional manner, Orangetree provided good custodial nursing care for Ms. Espinoza. It is vitally important

that Orangetree's positive role in this human tragedy not be overlooked.

Orangetree appreciates this opportunity to correct the record.



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